TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
Indemnity Insurance Company of North America

MFDR Tracking Number
M4-18-3909-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
June 12, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These medications do not require preauthorization therefore do not need a retrospective review."

Amount in Dispute: $702.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of the medical bill, a retrospective review was completed. The medications were determined not to be medically necessary based upon the retrospective review."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 25, 2017	Pharmaceutical Compound	$702.68	$702.68

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.240 sets out the procedures for reimbursement or denial of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
4. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 293
   - 940
   - 15

- 1
- 6
- 5280 – No additional reimbursement allowed after review of appeal/reconsideration
- 5281 – Non covered services
- W3 – Additional payment made on appeal/reconsideration.
- Notes: "The medical treatment was not authorized by the carrier"
- Notes: "Services not medically appropriate or necessary"

Issues

1. Is this dispute subject to dismissal due to medical necessity?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the disputed compound?

Findings

1. Memorial is seeking reimbursement for a compound dispensed on October 25, 2017. Per submitted explanation of benefits dated November 28, 2017, the pharmacy bill was originally received by the insurance carrier on or before this date.

   On submitted explanations of Benefits dated April 10, 2018, Trumbull denied the compound based on medical necessity. This date is more than 45 days after the date the original complete bill was received.[1]

   The insurance carrier has the obligation to dispute whether a treatment was medically necessary within 45 days after receiving a complete medical bill.[2] The Texas Department of Insurance, Division of Workers' Compensation (DWC) notes that the insurance carrier failed to present evidence of a denial for medical necessity within 45 days from the date it received the complete pharmacy bill. Therefore, the DWC finds that the dispute in question is not subject to dismissal based on this denial reason.

2. Because the insurance carrier failed to support its denial of reimbursement, the compound is covered, and Memorial is entitled to reimbursement in accordance with applicable rules and laws.

   The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately.[3] Each ingredient is listed below with its reimbursement amount.[4] The calculation of the total allowable amount is as follows:

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Gabapentin	38779246109	G	$59.85	3.6	$269.33	$204.66	$204.66
Bupivacaine	38779052405	G	$45.60	1.2	$68.40	$54.72	$54.72
Baclofen	38779038809	G	$35.63	5.4	$240.50	$190.78	$190.78
Amantadine	38779041105	G	$24.23	3	$90.84	$72.69	$72.69
Amitriptyline	38779018904	G	$18.24	1.8	$41.04	$32.83	$32.83
Ethoxy Diglycol	38779190301	G	$0.34	4.2	$1.80	$1.44	$1.44
Versapro Cream	38779252903	B	$3.20	40.8	$142.31	$130.56	$130.56
Fee	NA	NA	NA	NA	$15.00	$15.00	$15.00
						Total	$702.68

   The total reimbursement is therefore $702.68. This amount is recommended.

[1] 28 Texas Administrative Code §133.240(a)

[2] "A carrier has up to forty-five days from the date it receives a complete medical bill to dispute whether that treatment was necessary." State Office of Risk Management v. Lawton, 295 S.W.3d 646 (Tex. 2009), https://caselaw.findlaw.com/tx-supreme-court/1388209.html

[3] 28 Texas Administrative Code §134.502(d)(2)

[4] 28 Texas Administrative Code §134.503(c)

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $702.68.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $702.68, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	October 15, 2018
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.