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
TASB Risk Management Fund

MFDR Tracking Number
M4-18-4163-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
July 2, 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: $555.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "TASB-RMF considers any treatment that is not specifically cited, discussed, and approved in the current version of ODG, or is not FDA approved for the specific condition being treated, as being investigational or experimental … Please note that a peer review on 06/30/17 indicated that current treatment and medications are not related to the compensable injury … The appeal with a letter of medical necessity would have been considered by a TASB-RMF physician advisor for a professional opinion based on evidence-based medicine."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 25, 2017	Compound Medication	$555.68	$555.68

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 §133.210 sets out the requirements for medical documentation.
2. 28 Texas Administrative Code §133.305 sets out the procedures for resolving medical disputes.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.

5. 28 Texas Administrative Code §134.503 sets out the fee schedule for pharmaceutical services.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - Notes: "Please submit a letter of medical necessity showing why the use of a powder form of Tramadol would be needed or related to this injury."

Issues

1. Is the dispute in question subject to dismissal due to relatedness?
2. Is the dispute in question subject to dismissal due to medical necessity?
3. Is the insurance carrier's denial based on level of service supported?
4. Is the insurance carrier's denial based on submission or billing errors supported?
5. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the compound in question?

Findings

1. Memorial is seeking reimbursement for a compound dispensed on October 25, 2017. The insurance carrier denied the compound, in part, based on liability. A dispute regarding relatedness must be resolved prior to a request for medical fee dispute.[1]

   The respondent is required to attach a copy of any related Plain Language Notice (PLN) if the medical fee dispute involves relatedness to the compensable injury. Review of the submitted documentation finds that TASB Risk Management Fund failed to attach a copy of a related PLN to support a denial based on relatedness.

   The dispute in question is not subject to dismissal as this denial reason was not sufficiently supported.

2. TASB Risk Management Fund also denied the disputed compound based on medical necessity. Medical necessity disputes must be resolved prior to submission of a medical fee dispute.[2] The insurance carrier is required to perform a utilization review before a denial based on medical necessity, including giving the health care provider – in this case, Memorial – an opportunity to discuss the treatment in question.[3]

   The respondent is required to submit documentation to support a denial based on lack of medical necessity.[4] TASB Risk Management Fund provided no evidence to support that it performed a utilization review on the drugs in question to determine medical necessity.[5] This denial reason is not supported.

3. The insurance carrier also denied the compound in dispute stating the "information submitted does not support this level of service." The division finds that no documentation is required in addition to a pharmaceutical bill. No evidence was presented to support that additional information was requested in accordance with 28 TAC §133.210. The insurance carrier's denial for this reason is not supported.

4. TASB Risk Management Fund also denied the disputed compound based on submission or billing errors. Review of the documentation submitted does not support this denial reason.

5. Because the insurance carrier failed to sufficiently support its denial of reimbursement, Memorial is entitled to reimbursement.

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[1] 28 Texas Administrative Codes §§133.305(b) and 133.307(c)(1)(B)(i)
[2] 28 Texas Administrative Code §133.305(b)
[3] 28 Texas Administrative Code §133.240(q)
[4] 28 Texas Administrative Code §133.307(d)(2)(I)
[5] 28 Texas Administrative Codes §§134.240 and 19.2009

The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately.[6] Each ingredient is listed below with its reimbursement amount.[7] 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
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
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
Amitriptyline	38779018904	G	$18.24	1.8	$41.04	$32.83	$32.83
						Total	$555.68

The total reimbursement is therefore $555.68. This amount is recommended.

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 $555.68.

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 $555.68, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

______________________	Laurie Garnes	July 10, 2019
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.

[6] 28 Texas Administrative Code §134.502(d)(2)

[7] 28 Texas Administrative Code §134.503(c)