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
M4-18-4593-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
July 31, 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: $566.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It was processed … and denied based on peer review findings and for exceeding Official Disability Guidelines (ODG) … A peer review on file indicates that topical compounded medications are not supported by ODG and their use would not been supported."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 30, 2017	Compound Medication	$566.53	$566.53

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 (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to certified networks.

5. The insurance carrier denied payment based on the following claim adjustment reason codes:
    - 197 – Payment adjusted for absence of precertification/authorization
    - 114 – Procedure/product not approved by the Food and Drug Administration.
    - 55 – Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
    - 216 – Based on the findings of a review organization.
    - Notes: "Per Rule 137.100 treatment provided after May 1, 2007 must be in accordance with the Official Disability Guideline. Applies to all.
    - Notes: "Per Rule 134.530 Preauthorization is required for any drug identified as investigational or experimental for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined by labor code 413.014. The compound product is not used in an approved FDA form, therefore has not been approved by the FDA. Applies to all lines of the bill."
    - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
    - W3 – Additional payment made on appeal/reconsideration.

Issues

1. Is this dispute subject to dismissal based on medical necessity?
2. Is the insurance carrier's reason for denial of payment supported?
3. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the compound in question?

Findings

1. Memorial is seeking reimbursement for a compound dispensed on November 30, 2017. TASB Risk Management Fund (TASB-RMF) denied the disputed compound, in part, based on medical necessity.

   Medical necessity disputes must be resolved prior to submission of a medical fee dispute.[1] 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.[2]

   The respondent is required to submit documentation to support a denial based on lack of medical necessity.[3] TASB-RMF provided no evidence to support that it performed a utilization review to determine medical necessity.[4] This denial reason is not supported.

2. The insurance carrier denied the disputed compound based on preauthorization. Preauthorization is only required for:

    - drugs identified with a status of "N" in the current edition of the ODG Appendix A[5];
    - any compound that contains a drug identified with a status of "N" in the current edition of the ODG Appendix A; and
    - any investigational or experimental drug.[6]

   The compound in question does not contain an ingredient identified with a status of "N" in the current edition of the ODG, Appendix A.

[1] 28 Texas Administrative Code §133.305(b)
[2] 28 Texas Administrative Code §133.240(q)
[3] 28 Texas Administrative Code §133.307(d)(2)(I)
[4] 28 Texas Administrative Codes §§134.240 and 19.2009
[5] *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary*
[6] 28 Texas Administrative Code §134.530(b)(1)

The determination of a service's investigational or experimental nature is determined on a case by case basis through utilization review.[7] Utilization review, includes a prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services.[8]

TASB-RMF provided no evidence that the insurance carrier engaged in a prospective or retrospective utilization review to establish that the specific compound considered in this review is investigational or experimental.

Because the insurance carrier failed to perform utilization review on the disputed compound, the requirement for preauthorization based on a premise that the compound is investigational or experimental is not triggered in this case. The insurance carrier's preauthorization denial is therefore not supported.

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

   The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately.[9] Each ingredient is listed below with its reimbursement amount.[10] 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
Meloxicam	38779274601	G	$194.67	0.18	$43.80	$35.04	$35.04
Flurbiprofen	38779036209	G	$36.58	4.8	$219.48	$175.58	$175.58
Tramadol	38779237409	G	$36.30	6	$272.25	$217.80	$217.80
Cyclobenzaprine	38779039509	G	$46.33	1.8	$104.25	$83.39	$83.39
Bupivacaine	38779052405	G	$45.60	1.2	$68.40	$54.72	$54.72
						Total	$566.53

The total reimbursement is therefore $566.53. 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 $566.53.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor $566.53, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	April 23, 2019 Date

[7] Texas Insurance Code §19.2005(b)
[8] Texas Insurance Code §4201.002(13)
[9] 28 Texas Administrative Code §134.502(d)(2)
[10] 28 Texas Administrative Code §134.503(c)

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 DWC 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.