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**
New Hampshire Insurance Company

**MFDR Tracking Number**
M4-18-4653-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
August 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:** $566.53

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "This bill was denied for lack of medical necessity, based upon the attached UR."

**Response Submitted by:** Flahive, Ogden & Latson

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| November 29, 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.

**Background**

1. 28 Texas Administrative Code §133.305 sets out the procedures for resolving medical disputes.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
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 guidelines for pharmaceutical services.
6. 28 Texas Administrative Code, Chapter 19 sets out the requirements for utilization review.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - X435 – Based on peer review, further treatment is not recommended.

- X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due.

**Issues**

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

**Findings**

1. Memorial is seeking reimbursement for a compound dispensed on November 29, 2017 with the following ingredients:

| Ingredient | Amount |
|---|---|
| Meloxicam | 0.18 gm |
| Flurbiprofen | 4.8 gm |
| Tramadol | 6.0 gm |
| Cyclobenzaprine | 1.8 gm |
| Bupivacaine | 1.2 gm |

New Hampshire Insurance Company denied the compound based on medical necessity as determined by utilization review.

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 for the service in question, including giving the health care provider – in this case, Memorial – an opportunity to discuss the treatment in question.[2]

Flahive, Ogden & Latson submitted a document on behalf of the insurance carrier dated November 16, 2017, to support its denial of the compound in question. The submitted document does not support that New Hampshire Insurance Company performed a utilization review for the compound considered in this dispute as this document does not address the compound ingredients as billed and presented in this dispute.

The Texas Department of Insurance, Division of Workers' Compensation concludes that this dispute is not subject to dismissal based on medical necessity.

2. Because the insurance carrier's denial reasons are not supported, the compound in question is eligible for 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 |
|---|---|---|---|---|---|---|---|
| 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 allowable reimbursement for the compound in dispute is $566.53. This amount is recommended.

[1] 28 Texas Administrative Code §133.305(b)
[2] 28 Texas Administrative Code §133.240(q)
[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 $566.53.

## *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 $566.53, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

| | Laurie Garnes | November 7, 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**.