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
City of Houston

MFDR Tracking Number
M4-18-4717-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
August 3, 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: "… the compound drug was determined not to be medically necessary by Respondent's utilization review agent following a retrospective utilization review."

Response Submitted by: Stone Loughlin Swanson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 14, 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 §133.240 sets out the procedures for payment or denial of a medical bill.
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 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 compound based on medical necessity.

Issues

1. Is this dispute subject to dismissal based on 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 November 14, 2017. The insurance carrier denied the disputed compound ingredients, in part, based on medical necessity.

   If a dispute regarding medical necessity exists, the medical necessity dispute must be resolved prior to a request for medical fee dispute resolution.[1] A medical necessity denial of a medical bill must be based on an adverse determination by a utilization review agent.[2]

   The respondent is required to include documentation to support a denial based on adverse determination.[3] The submitted documentation includes a report dated November 28, 2017, as support for utilization review of the disputed compound. This report is for a drug not considered in this dispute and does not support that the insurance carrier performed a utilization review of the compound in question.

   For this reason, the insurance carrier's denial is not sufficiently supported. This dispute is not subject to dismissal based on medical necessity.

2. 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.[4] Each ingredient is listed below with its reimbursement amount.[5] 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.

[1] 28 Texas Administrative Code §133.305(b)
[2] 28 Texas Administrative Code §133.240(q), 28 Texas Administrative Codes §§19.2009 and 19.2010
[3] 28 Texas Administrative Code §133.307(d)(2)(I)
[4] 28 Texas Administrative Code §134.502(d)(2)
[5] 28 Texas Administrative Code §134.503(c)

Authorized Signature

	Laurie Garnes	April 23, 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.