



# 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**

Sentinel Insurance Company Ltd

**MFDR Tracking Number**

M4-18-4762-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

August 6, 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:** "Retro review performed on the disputed medication. Determination was not approved to process. This prescriber has not submitted any medical reports ... Lack of information letter sent to Dr. Shabrez and Memorial Compounding RX."

**Response Submitted by:** The Hartford

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 14, 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**

- 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of medical bills.
- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
- 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
- 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to certified networks.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 75 – Prior authorization required
  - P2 – Not a work related injury/illness and thus not the liability of the workers' compensation carrier.

### **Issues**

1. Is this dispute subject to dismissal due to the compensability of the injury?
2. Did the insurance carrier raise a new defense in its response?
3. Is the insurance carrier's reason for denial of payment based on preauthorization supported?
4. 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, in part, based on the liability of the injury. Per submitted explanation of benefits dated on December 13, 2017, the pharmacy bill was originally received by the insurance carrier on or before this date. This explanation of benefits did not raise the issue of liability.

Explanation of benefits dated April 27, 2018, denying the compound based on liability is more than 45 days after the date the original complete bill was received.<sup>1</sup>

The insurance carrier has the obligation to dispute whether a treatment was for the compensable injury within 45 days after receiving a complete medical bill.<sup>2</sup> The DWC notes that the insurance carrier failed to present evidence of a denial for compensability presented to Memorial 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. In its position statement, The Hartford, on behalf of the insurance carrier, argued that the compound was denied for medical necessity and lack of documentation.

The response from the insurance carrier is required to address only the denial reasons presented to the requestor before the medical fee dispute resolution (MFDR) was filed with the Texas Department of Insurance, Division of Workers' Compensation (DWC). Any new denial reasons or defenses raised shall not be considered in this review.<sup>3</sup>

The submitted documentation does not support that denials based on medical necessity or lack of documentation were provided to Memorial before this request for MFDR was filed. Therefore, the DWC will not consider these arguments in the current dispute review.

3. The explanation of benefits submitted for the service specified in this dispute indicates that the insurance carrier denied the compound based on preauthorization. Preauthorization for compounds is only required for:

- any compound that contains a drug identified with a status of "N" in the current edition of the ODG Appendix A<sup>4</sup>; and
- any investigational or experimental drug.<sup>5</sup>

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

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<sup>1</sup> 28 Texas Administrative Code §133.240(a)

<sup>2</sup> "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>

<sup>3</sup> 28 Texas Administrative Code §133.307(d)(2)(F)

<sup>4</sup> ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary

<sup>5</sup> 28 Texas Administrative Code §134.540(b)

The determination of a service’s investigational or experimental nature is determined on a case by case basis through utilization review.<sup>6</sup> The insurance carrier provided no evidence that it engaged in a prospective or retrospective utilization review to establish that the specific compound considered in this review is investigational or experimental. The insurance carrier’s preauthorization denial is therefore not supported.

4. 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.<sup>7</sup> Each ingredient is listed below with its reimbursement amount.<sup>8</sup> 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
						<b>Total</b>	<b>\$566.53</b>

The total allowable for the disputed compound is \$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 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**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Laurie Garnes  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
November 27, 2018  
Date

<sup>6</sup> Texas Insurance Code §19.2005(b)

<sup>7</sup> 28 Texas Administrative Code §134.502(d)(2)

<sup>8</sup> 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 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.**