Texas Department of Insurance

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
City of Houston

MFDR Tracking Number
M4-19-0092-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
September 7, 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: $834.03

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 retrospective utilization reviews."

Response Submitted by: Injury Management Organization

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 28, 2018	Compound Medication	$566.53	$0.00
February 28, 2018	Lenzapatch 4%-1%	$267.50	$232.90
	Total	$834.03	$232.90

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 general medical dispute resolution guidelines.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedure for dispute resolution of medical necessity disputes.
4. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Notes: "Denied Per Retrospective Peer Review Determination"
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. Is the insurance carrier's denial of payment based on medical necessity supported?
2. Is the requestor entitled to reimbursement for this dispute?

Findings

1. Memorial is seeking reimbursement for drugs dispensed on February 28, 2018. The drugs in dispute are Lenzapatch 4%-1% and a compound containing the following ingredients:

   - Meloxicam,
   - Flurbiprofen,
   - Tramadol HCl,
   - Cyclobenzaprine HCl, and
   - Bupivacaine HCl.

   The insurance carrier denied the drugs in question based on medical necessity. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding…medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding…medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021."

   The submitted documentation includes a utilization review with an adverse determination for the compound considered in this dispute.

   The DWC finds that the disputed services contain unresolved issues of medical necessity for the compound included in this medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical bill review process.

   The DWC hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at http://www.tdi.texas.gov/hmo/iro_requests.html under ***Health Care Providers or their authorized representatives***.

   The documentation submitted does not include a utilization review performed for Lenzapatch 4%-1% to support a denial based on an adverse determination. The insurance carrier's denial for this drug is not supported.

2. Because the insurance carrier failed to support its denial of payment for Lenzapatch 4%-1%, Memorial is entitled to reimbursement for the drug in question.

   The reimbursement considered in this dispute is calculated in accordance with 28 Texas Administrative Code §134.503(c) as follows:

   - Lenzapatch 4%-1%: (42.0 x 5 x 1.09) + $4.00 = $232.90

   The total reimbursement is therefore $232.90. This amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $232.90.

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 $232.90, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

______________________	Laurie Garnes	August 29, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.