



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

Accident Fund Insurance Company of America

MFDR Tracking Number

M4-19-0466-01

Carrier's Austin Representative

Box Number 6

MFDR Date Received

September 27, 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: \$293.67

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor is not entitled to payment because the medications in dispute were prescribed to treat a non-compensable condition."

Response Submitted by: Stone Loughlin Swanson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 11, 2018	Tramadol HCl 50 mg Tablets	\$90.82	\$45.64
April 11, 2018	Meloxicam 15 mg Tablets	\$202.85	\$185.69
	Total	\$293.67	\$231.33

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 §134.530 sets out the closed formulary requirements for claims not subject to certified networks.

7. Texas Insurance Code, Chapter 19 sets out the requirements for utilization review.
8. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 203 – Peer review has determined – payment for treatment has not been recommended due to the lack of medical necessity. Peer review has provided its findings to the provider in prior documentation.
 - 216 – Based on the findings of a review organization.
 - P12 – Workers’ compensation jurisdictional fee schedule adjustment.
 - 4282 – Drugs identified with a status of “Y” in the current edition of the “Official Disability Guidelines Treatment in Workers’ Comp” (ODG)/Appendix A, “ODG Workers’ Compensation Drug Formulary” identify a drug that can dispensed without a preauthorization. The allowance has been determined in according to the pharmacy fee guidelines.

Issues

1. Is this dispute subject to dismissal based on the extent of the compensable injury?
2. Is this dispute subject to dismissal based on medical necessity?
3. Is the insurance carrier’s denial of payment based on preauthorization supported?
4. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drugs in question?

Findings

1. Memorial is seeking reimbursement for drugs dispensed on April 11, 2018. In its position statement the insurance carrier argued that the disputed drug was denied based on the extent of the compensable injury.

The response from the insurance carrier is required to address only the denial reasons presented to the requestor the request for medical fee dispute resolution (MFDR) was filed with the division. Any new denial reasons or defenses raised shall not be considered for review.¹

The submitted documentation does not support that a denial based on the extent of the compensable injury was provided to Memorial before this request for MFDR was filed. Therefore, the division will not consider this argument in the current dispute review as this issue constitutes new defenses.

2. Per explanation of benefits dated July 19, 2018, the insurance carrier denied the disputed, 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.² A medical necessity denial of a medical bill must be based on an adverse determination by a utilization review agent.³

The submitted documentation includes a report dated February 2, 2018. This report does not support that the insurance carrier performed a utilization review of the compound in question for the following reasons⁴:

- The document does not include evidence that the insurance carrier afforded the health care provider a reasonable opportunity to discuss the medical necessity of the compound.
- The document does not include a description for filing a complaint with the Texas Department of Insurance,
- The document does not include information describing the processes for filing an appeal,

For these reasons, the insurance carrier’s denial is not sufficiently supported. This dispute is not subject to dismissal based on medical necessity.

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

¹ 28 Texas Administrative Code §133.307(d)(2)(F)

² 28 Texas Administrative Code §133.305(b)

³ 28 Texas Administrative Code §133.240(q), 28 Texas Administrative Codes §§19.2009 and 19.2010

⁴ 28 Texas Administrative Code §19.2009(b)

- drugs identified with a status of “N” in the current edition of the ODG Appendix A⁵;
- 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

Stone Loughlin Swanson argued on behalf of the insurance carrier that “Meloxicam is identified with the status of ‘N’ in *Appendix A* of the ODG Workers’ Compensation Drug Formulary when in the form of Vivlodex.”

Review of the ODG, Appendix A finds that the brand name formulation of Meloxicam, Vivlodex, has a status of “N” with no generic equivalents. Meloxicam as sought by Memorial, NDC 29300012510, is found to be a **generic** form of Meloxicam, which carries a status of “Y” in the ODG, Appendix A. The DWC concludes that the drugs in question are not identified with a status of “N” in the current edition of the ODG, Appendix A.

The determination of a service’s investigational or experimental nature is determined on a case by case basis through utilization review.⁷ Stone Loughlin Swanson provided no argument or evidence that the insurance carrier engaged in a prospective or retrospective utilization review to establish that the specific drugs considered in this review is investigational or experimental.

The DWC finds that the insurance carrier failed to support that the compound in question required preauthorization.

4. Because the insurance carrier failed to support its denial, Memorial is entitled to reimbursement for the drugs in question. The calculation of the total allowable amount is as follows:

- Tramadol 50 mg tablets: $(0.83289 \times 40 \times 1.25) + \$4.00 = \$45.64$
- Meloxicam 15 mg tablets: $(4.845 \times 30 \times 1.25) + \$4.00 = \$185.69$

The total allowable amount is \$231.33. 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 \$231.33.

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 \$231.33, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	July 16, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

⁵ ODG *Treatment in Workers’ Comp* (ODG) / Appendix A, *ODG Workers’ Compensation Drug Formulary*
⁶ 28 Texas Administrative Code §134.530(b)(1)
⁷ Texas Insurance Code §19.2005(b)

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.