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
Tx Public School WC Project

MFDR Tracking Number
M4-19-0553-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
October 1, 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: $267.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CRF contends that the pharmacy billing in question does not relate to an ongoing compensable condition, and that the medication in question was not medically necessary for treatment of the claimant's compensable injury in accordance with a peer review report dated September 15, 2017."

Response Submitted by: Creative Risk Funding

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 29, 2018	Lenzapatch 4%-1%	$267.50	$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 §133.240 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 §134.503 sets out the fee guidelines for pharmaceutical services.
5. Texas Insurance Code, Chapter 19 sets out the requirements for utilization review.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 216 – Based on the findings of a review organization

- 96 – Non-covered charge(s).
- Notes: "SEE ATTACHED PEER REVIEW REPORT DATED 9/15/17"
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- Notes: "PEER REVIEW DATED 09.15.2017 ATTACHED FOR PROVIDER. FINAL ACTION."

Issues

1. Is this dispute subject to dismissal based on relatedness to/extent of the compensable injury?
2. Is this dispute subject to dismissal based on medical necessity?
3. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drugs in question?

Findings

1. Memorial is seeking reimbursement for Lenzapatch 4%-1% dispensed on January 29, 2018. The insurance carrier denied the drug based on relatedness to/extent of the compensable injury. A dispute regarding relatedness to/extent of the compensable injury must be resolved prior to a request for medical fee dispute.[1]

   The respondent is required to attach a copy of any related Plain Language Notice (PLN) if the medical fee dispute involves relatedness to/extent of the compensable injury.[2] Review of the submitted documentation finds that Creative Risk Funding failed to attach a copy of a related PLN on behalf of the insurance carrier to support a denial based on relatedness to/extent of the compensable injury.

   The dispute in question is not subject to dismissal as this denial reason was not sufficiently supported.

2. Per explanations of benefits dated February 15, 2018, and September 4, 2018, the insurance carrier denied the disputed compound 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.[3] A medical necessity denial of a medical bill must be based on an adverse determination by a utilization review agent.[4]

   The submitted documentation includes a report dated September 15, 2017, as support for utilization review of the disputed compound. This report does not support that the insurance carrier performed a utilization review of the compound in question for the following reasons[5]:

   - 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,
   - The document itself includes the statement, "In and of itself, this opinion does not constitute a recommendation for specific claims or administrative functions to be made or enforced."

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

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

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

   The total allowable amount is $232.90. This amount is recommended.

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

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 $232.90.

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 $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	July 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.