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
Graphic Arts Mutual Insurance Company

MFDR Tracking Number
M4-19-0594-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
October 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: $566.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The treatment associated with these charges was non certified by Genex utilization review as not reasonable or necessary and therefore not owed by a workers compensation carrier."

Response Submitted by: Utica National Insurance Group

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 11, 2018	Compound Medications	$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

1. 28 Texas Administrative Code §133.240 sets out the procedures for payment and denial of medical bills.
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. 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to certified networks.
6. Texas Insurance Code, Chapter 19 sets out the requirements for utilization review.

7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 216 – Based on the findings of a review organization.
   - 39 – Services denied at the time authorization/pre-certification was requested.
   - 50 – These are non-covered services because this is not deemed a medical necessity' by the payer.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - Notes: "NO ADDITIONAL PAYMENT RECOMMENDED AS APPROVAL MUST BE GIVEN BY ADJ

Issues

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

Findings

1. Memorial is seeking reimbursement for a compound dispensed on January 11, 2018. Per explanation of benefits dated January 25, 2018, the insurance carrier denied the disputed compound, in part, based on medical necessity.

   Medical necessity disputes must be resolved prior to submission of a medical fee dispute.[1] The insurance carrier is required to perform a utilization review before a denial based on medical necessity, including giving the health care provider – in this case, Memorial – an opportunity to discuss the treatment in question.[2]

   The respondent is required to submit documentation to support a denial based on lack of medical necessity.[3] The submitted documentation includes a report dated November 8, 2017, as support for utilization review of the disputed compound. This document is not a review of the compound considered in this dispute. The insurance carrier provided no evidence to support that it performed a utilization review of the compound in question to determine medical necessity.[4]

   This denial reason is not supported. This dispute is not subject to dismissal based on medical necessity.

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

   - drugs identified with a status of "N" in the current edition of the ODG Appendix A[5];
   - any prescription drug created through compounding prescribed before July 1, 2018, that contains a drug identified with a status of "N" in the current edition of the ODG Appendix A;
   - any prescription drug created through compounding prescribed and dispensed on or after July 1, 2018; and
   - any investigational or experimental drug.[6]

   The compound in question was prescribed before July 1, 2018 and does not contain an ingredient 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] The insurance carrier provided no evidence that the insurance carrier engaged in a prospective or retrospective utilization review to establish that the specific compound considered in this review is investigational or experimental.

[1] 28 Texas Administrative Code §133.305(b)
[2] 28 Texas Administrative Code §133.240(q)
[3] 28 Texas Administrative Code §133.307(d)(2)(I)
[4] 28 Texas Administrative Codes §§134.240 and 19.2009
[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)

Because the insurance carrier failed to perform utilization review on the disputed compound, the requirement for preauthorization based on a premise that the compound is investigational or experimental is not triggered in this case. The insurance carrier's preauthorization denial is therefore not supported.

3. 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.[8] Each ingredient is listed below with its reimbursement amount.[9] 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
						Total	$566.53

   The total allowable reimbursement for the compound in dispute is $566.53. 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 $566.53.

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 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	Medical Fee Dispute Resolution Officer	Date
	Laurie Garnes	July 29, 2019

[8] 28 Texas Administrative Code §134.502(d)(2)
[9] 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.