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
Lamar CISD

MFDR Tracking Number
M4-19-1060-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
October 25, 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: $583.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 27, 2018	Compound Medication	$583.89	$583.89

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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical compounds.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment reason codes:
    - T165 – Payment has been denied/reduced for absence of or exceeding the referral.
    - T216 – Based on the findings of a review organization. Peer review or RME.

Issues

1. Did Lamar CISD respond to the medical fee dispute?
2. Is this dispute subject to dismissal based on medical necessity?
3. Is the insurance carrier's denial based on an exceeded referral supported?
4. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the compound in question?

Findings

1. The insurance carrier's Austin representative acknowledged receipt of the copy of this medical fee dispute on November 5, 2018. The insurance carrier's response is considered timely if it is submitted within 14 calendar days after the date the insurance carrier's representative received the copy of the dispute. If a response is not received within 14 calendar days of the dispute notification, then the decision may be based on the available information.[1]

   No response has been received on behalf of Lamar CISD to date. For that reason, the decision will be based on the information available.

2. Per explanation of benefits dated March 19, 2018, the insurance carrier denied the disputed compound based on medical necessity.

   Medical necessity disputes must be resolved prior to submission of a medical fee dispute.[2] 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.[3]

   The respondent is required to submit documentation to support a denial based on lack of medical necessity.[4] Lamar CISD provided no evidence to support that it performed a utilization review on the drugs in question to determine medical necessity.[5] This denial reason is not supported.

3. Per explanation of benefits dated March 19, 2018, the insurance carrier also denied the disputed compound based on "absence or exceeding referral." The documentation submitted does not support this denial reason.

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.[6] Each ingredient is listed below with its reimbursement amount.[7] 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 reimbursement is therefore $566.53. This amount is recommended.

[1] 28 Texas Administrative Code §133.307(d)(1)
[2] 28 Texas Administrative Code §133.305(b)
[3] 28 Texas Administrative Code §133.240(q)
[4] 28 Texas Administrative Code §133.307(d)(2)(I)
[5] 28 Texas Administrative Codes §§134.240 and 19.2009
[6] 28 Texas Administrative Code §134.502(d)(2)
[7] 28 Texas Administrative Code §134.503(c)

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

	Laurie Garnes	May 2, 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.