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
TPCIGA FOR LUMBERMENS' MUTUAL CASUALTY COMPANY

MFDR Tracking Number
M4-19-1111-01

Carrier's Austin Representative
Box Number 50

MFDR Date Received
October 29, 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: $555.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "These services were sent for Retrospective Utilization Review and determined to be outside of the ODG (Official Disability Guidelines) and therefore not medically necessary."

Response Submitted by: Texas Property & Casualty Insurance Guaranty Association/ReviewMed

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
February 7, 2018	Pharmaceutical Compound	$555.68	$555.68

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 §133.240 sets out provisions regarding medical payments and denials.
3. 28 Texas Administrative Code §134.503 sets out the fee guideline for pharmacy services.
4. The insurance carrier denied payment based on the following claim adjustment codes:
   - 216 – BASED ON THE FINDINGS OF A REVIEW ORGANIZATION.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W3 – [No description of this code was found with the submitted materials.]

Issues

1. Are there any unresolved issues of medical necessity?
2. What is the recommended reimbursement for the disputed pharmaceutical compound?

Findings

1. The requestor is seeking reimbursement for a compounded medication dispensed on February 7, 2018.

   The insurance carrier denied payment for the disputed compound based on the findings of a review organization.

   Based on submitted information, the carrier received the pharmacy's bill on February 15, 2018. The explanation of benefits (EOB) denying payment for the bill is dated April 10, 2018. This date is later than the 45th day following carrier receipt of the disputed bill.

   Rule §133.240(a) requires an insurance carrier to take final action after bill review not later than the 45th day after the date the insurance carrier received a complete medical bill. Rule §133.240(e)(2)(A) further requires carriers to send an EOB when denying payment due to an adverse determination. And Rule §133.307(d)(2)(B) requires respondents to provide to MFDR a paper copy of all EOBs related to the dispute.

   Review of the submitted information finds the respondent failed to support taking final action within 45 days of receipt of the pharmacy bill. The Texas Supreme Court has held, based on Rule §133.240(a), "A carrier has up to forty-five days from the date it receives a complete medical bill to dispute whether that treatment was necessary." [1] Because the insurance carrier failed to dispute the medical necessity of the treatment within the time limit, the carrier has waived the right to dispute the necessity of that treatment altogether.

   Consequently, the division concludes there are no unresolved issues of medical necessity and the fee issues are eligible for review. The insurance carrier's denial reasons are not supported. The disputed compound will therefore be reviewed for payment in accordance with division rules and fee guidelines.

2. This dispute regards a pharmaceutical compound with reimbursement subject to the *Pharmacy Fee Guideline*, 28 Texas Administrative Code §134.503(c), requiring the insurance carrier to reimburse prescription drugs the lesser of: (1) the fee established by formula in the rule based on the average wholesale price (AWP) as reported by nationally recognized pharmaceutical pricing data; or (2) the amount billed.

   Reimbursement is calculated as follows:

Ingredient(s)	NDC & Type	Unit Price	Total Units	AWP Formula §134.503(c)(1)	Billed Amount §134.503(c)(2)	Lesser of (c)(1) or (c)(2)
BACLOFEN	38779038809 Generic	$35.63	5.4	($35.63 × 5.4) × 1.25 = $240.50	$190.78	$190.78
AMANTADINE HCL	38779041105 Generic	$24.23	3	($24.23 × 3) × 1.25 = $90.84	$72.69	$72.69
GABAPENTIN	38779246109 Generic	$59.85	3.6	($59.85 × 3.6) × 1.25 = $269.33	$204.66	$204.66
BUPIVACAINE HCL	38779052405 Generic	$45.60	1.2	($45.60 × 1.2) × 1.25 = $68.40	$54.72	$54.72
AMITRIPTYLINE HCL	38779018904 Generic	$18.24	1.8	($18.24 × 1.8) × 1.25 = $41.04	$32.83	$32.83
		Total Units:	15		Subtotal:	$555.68
					+ $15 compound fee = **Total**:	$570.68

   The total reimbursement for the medication in dispute is $570.68. The requestor is seeking $555.68. This amount is recommended.

[1] "A carrier has up to forty-five days from the date it receives a complete medical bill to dispute whether that treatment was necessary." *State Office of Risk Management v. Lawton*, 295 *South Western Reporter Third* 646 (Texas 2009), http://www.search.txcourts.gov/historical/2009/aug/080363.pdf

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

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 $555.68.

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 $555.68, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	December 7, 2018
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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.