



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

Service Lloyds Insurance Company

MFDR Tracking Number

M4-19-1260-01

Carrier's Austin Representative

Box Number 1

MFDR Date Received

November 5, 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: \$834.03

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are upholding the original review. The bill has been reviewed by utilization review and determined to be not medically necessary..."

Response Submitted by: AViDEL Medical Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 29, 2018	Compound Medications	\$566.53	\$566.53
March 29, 2018	Lenzapatch 4%-1%	\$267.50	\$232.90
Total		\$834.03	\$799.43

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 services.
3. Texas Labor Code §408.021 establishes entitlement to medical benefits.
4. Texas Insurance Code §1305.101 defines the duties of networks to provide medical treatment.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 95 – Plan procedures not followed.

- U02 – The billed service was reviewed by UR and denied.
- 791 – This item is reimbursed as a brand-name prescribed drug.
- 91 – Dispensing fee adjustment.
- Notes: “UR determined not medically necessary...”

Issues

1. Is this dispute subject to dismissal based on medical necessity?
2. Is the insurance carrier’s denial of payment based on network procedures supported?
3. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the disputed drug?

Findings

1. Memorial is seeking reimbursement for drugs dispensed on March 29, 2018. Per explanations of benefits dated April 13, 2018, and October 12, 2018, the insurance carrier denied the disputed drugs, 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 AVIDEL Medical Management provided no evidence on behalf of Service Lloyds Insurance Company to support that it performed a utilization review on 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 reimbursement asserting that the drugs were provided outside the certified health care network.

Prescription medication may not, directly or through a contract, be delivered through a workers’ compensation health care network.⁵

The division concludes that the disputed prescription medication dispensed by the provider in this case – Memorial Compounding Pharmacy – is not subject to the provisions of a workers’ compensation health care network. Continental Insurance Company’s denial for this reason is 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.⁶ Each ingredient is listed below with its reimbursement amount.⁷ The calculation of the total allowable amount is as follows:

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)(l)

⁴ 28 Texas Administrative Codes §§134.240 and 19.2009

⁵ Texas Insurance Code §1305.101(c)

⁶ 28 Texas Administrative Code §134.502(d)(2)

⁷ 28 Texas Administrative Code §134.503(c)

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

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

The total reimbursement is therefore \$799.43. 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 \$799.43.

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 \$799.43, 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.