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
Liberty Insurance Corp

MFDR Tracking Number
M4-19-1306-01

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: $837.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It was denied as not medically necessary following completion of a retrospective medical necessity review."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 4, 2018	Compound Medication	$569.93	$569.93
March 4, 2018	Lenzapatch 4% - 1% PHA	$267.50	$0.00
	Total	$837.43	$569.93

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 §134.502 sets out the procedures for pharmaceutical benefits.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to certified networks.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - X484 – According to the Texas Division of Workers Compensation's Rules effective May 1, 2007, all medical treatment provided to workers compensation patients in the state of Texas must follow the official disability guidelines (ODG). The services provided are outside the ODG Guidelines and no pre authorization was requested.

Issues

1. Did the insurance carrier raise a new defense in its response?
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 medications dispensed on March 4, 2018. In its position statement the insurance carrier argued that the disputed drug was denied based on medical necessity.

   The response from the insurance carrier is required to address only the denial reasons presented to the requestor the request for medical fee dispute resolution (MFDR) was filed with the DWC. Any new denial reasons or defenses raised shall not be considered for review.[1]

   The submitted documentation does not support that a denial based on medical necessity was provided to Memorial before this request for MFDR was filed. Therefore, the DWC will not consider this argument in the current dispute review as this issue constitutes a new defense.

2. Submitted documentation supports that 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[2];
   - any compound 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 compound prescribed and dispensed on or after July 1, 2018; and
   - any investigational or experimental drug.[3]

   The division finds that Lenzapatch 4%-1% includes Lidocaine, which is an "N" drug in the ODG/Appendix A. The documentation submitted does not provide evidence that a preauthorization was obtained. No reimbursement can be recommended for this service.

   The compound in question, prescribed before July 1, 2018, does not contain an ingredient identified with a status of "N" in the current edition of the ODG, Appendix A.

3. Because the insurance carrier failed to sufficiently support its denial of reimbursement, Memorial is entitled to reimbursement for the compound listed above.

   The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately.[4] Each ingredient is listed below with its reimbursement amount.[5] The calculation of the total allowable amount is as follows:

[1] 28 Texas Administrative Code §133.307(d)(2)(F)
[2] *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary*
[3] 28 Texas Administrative Code §134.530(b)(1)
[4] 28 Texas Administrative Code §134.502(d)(2)
[5] 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
Gabapentin USP	38779246109	G	$59.85	3	$224.44	$179.55	$179.55
Amitriptyline HCl	38779018904	G	$18.24	2.4	$54.72	$43.78	$43.78
Amantadine HCl	38779041105	G	$24.23	4.8	$145.35	$116.30	$116.30
Flurbiprofen	38779036209	G	$36.58	4.8	$219.48	$175.58	$175.58
Bupivacaine HCl	38779052405	G	$45.60	1.2	$68.40	$54.72	$54.72
Fee	NA	NA	NA	NA	$15.00	$15.00	$15.00
						Total	$584.93

The total reimbursement is therefore $584.93. Memorial is seeking $569.93 for the compound in question. 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 $569.93.

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 $569.93, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	July 16, 2019 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.