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
New Hampshire Insurance Company

MFDR Tracking Number
M4-19-1352-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 8, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027."

Amount in Dispute: $970.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment has been disputed as the medication was not found to be medically necessary."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 17, 2018	Compound Medication	$702.68	$702.68
June 17, 2018	Lenzapatch 4%-1%	$267.50	$232.90
	Total	$970.18	$935.58

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 or denial of a medical bill.
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 §134.502 sets out the procedures for pharmaceutical benefits.
5. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
6. 28 Texas Administrative Code, Chapter 19 sets out the requirements for utilization review.
7. The insurance carrier reduced payment for the disputed services based on medical necessity.

Issues

1. Is this dispute subject to dismissal based on medical necessity?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the disputed compound?

Findings

1. Memorial is seeking reimbursement for Lenzapatch 4%-1% and a compound dispensed on June 17, 2018. Per explanation of benefits dated June 28, 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.[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]

   Broadspire submitted a document on behalf of New Hampshire Insurance Company, dated July 17, 2018, to support its denial of the disputed compound. The Texas Department of Insurance, Division of Workers' Compensation (DWC) finds that the submitted document does not support that the insurance carrier performed a utilization review for the compound in question as Broadspire provided no evidence that Memorial was given an opportunity to discuss the compound prior to the insurance carrier's denial based on medical necessity.[3]

   The DWC concludes that this dispute is not subject to dismissal based on medical necessity.

2. Because the insurance carrier failed to support its denial of reimbursement, Memorial is entitled to reimbursement in accordance with applicable rules and laws.

   The reimbursement for Lenzapatch 4%-1% as considered in this dispute is calculated as follows:

   - (42.00 x 5 x 1.09) + $4.00 = $232.90

   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:

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Baclofen	38779038809	G	$35.63	5.4	$240.50	$190.78	$190.78
Amantadine	38779041105	G	$24.23	3	$90.84	$72.69	$72.69
Gabapentin	38779246109	G	$59.85	3.6	$269.33	$204.66	$204.66
Bupivacaine	38779052405	G	$45.60	1.2	$68.40	$54.72	$54.72
Amitriptyline	38779018904	G	$18.24	1.8	$41.04	$32.83	$32.83
Ethoxy Diglycol	38779190301	G	$0.34	4.2	$1.80	$1.44	$1.44
Versapro Cream	38779252903	B	$3.20	40.8	$142.31	$130.56	$130.56
Fee	NA	NA	NA	NA	$15.00	$15.00	$15.00
						Total	$702.68

   The total allowable reimbursement for the compound in dispute is $935.58. 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 $935.58.

[1] 28 Texas Administrative Code §133.305(b)
[2] 28 Texas Administrative Code §133.240(q)
[3] 28 Texas Administrative Code §19.2009(b)
[4] 28 Texas Administrative Code §134.502(d)(2)
[5] 28 Texas Administrative Code §134.503(c)

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 $935.58, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_______________	Laurie Garnes	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, 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.