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
HARRIS COUNTY

MFDR Tracking Number
M4-19-1373-01

Carrier's Austin Representative
Box Number 21

MFDR Date Received
November 8, 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: "the medications were determined not medical necessary upon retrospective review to treat the compensable injury."

Response Submitted by: Thornton Biechlin Reynolds & Guerra and Stone Loughlin Swanson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 17, 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 §133.2 defines words and terms related to medical bill processing.
3. 28 Texas Administrative Code §133.230 sets out requirements for insurance carrier audit of medical bills.
4. 28 Texas Administrative Code §133.240 sets out procedures for medical bill payments and denials.
5. 28 Texas Administrative Code §133.250 sets out procedures for reconsideration of payment for medical bills.
6. 28 Texas Administrative Code §134.500 defines words and terms relating to pharmaceutical benefits.
7. 28 Texas Administrative Code §134.503 sets out the fee guideline for pharmacy services.
8. 28 Texas Administrative Code §134.530 sets out closed formulary requirements for non-network claims.
9. 28 Texas Administrative Code Chapter 19, Subchapter U sets out rules for utilization review of health care.
10. 28 Texas Administrative Code §19.2005 sets out general standards of utilization review.
11. Texas Insurance Code §4201.002 defines words and terms related to utilization review.
12. Texas Labor Code §408.021 entitles an injured employee to all required health care as and when needed.
13. The insurance carrier denied payment based on the following claim adjustment codes:
    - 197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.

- 216 – BASED ON THE FINDINGS OF A REVIEW ORGANIZATION.

Issues

1. Are there any outstanding issues of medical necessity?
2. Did the dispensed medication require preauthorization?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier initially denied the disputed medication dispensed April 17, 2018 by explanation of benefits (EOB) dated May 1, 2018 with claim adjustment reason code 197 – "Payment denied/reduced for absence of precertification/authorization."

   After request for reconsideration, the carrier issued a subsequent EOB on September 27, 2018 denying payment using claim adjustment reason code 216 – "Based on the findings of a review organization." However, no findings of a review organization related to the date of service were included with the insurance carrier's response.

   Rule §133.307(d)(2) requires the respondent to provide with their response any missing information not provided by the requestor and known to the respondent. Rule §133.307(d)(1) provides that if the division does not receive the required response information within 14 calendar days of dispute notification, then the division may base its decision on the available information. Accordingly, the findings and decision in this dispute are based on the information available at the time of review.

   The respondent provided three adverse determinations related to medications dispensed on other service dates; however, the carrier did not provide any adverse determinations or documents supporting utilization review of the disputed compound dispensed April 17, 2018.

   Texas Labor Code Sec. 408.027(b), requires carriers to "pay, reduce, deny, or determine to audit the health care provider's claim not later than the 45th day after the date of receipt by the carrier of the provider's claim."

   Corresponding Rule §133.240(a) requires that the insurance carrier shall:

   > take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

   Rule §133.2(6) defines "final action" as: (A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement . . . and/or (B) denying a charge on the medical bill.

   Rule §133.230(a) prohibits a carrier from auditing a bill on which it has already taken final action (that is, paid or denied). And the opportunity to audit is not reopened during the reconsideration phase.

   The Texas Supreme Court has held that "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)

   Rule §133.250(g) requires carriers to take final action on a reconsideration request within 30 days of receipt of that request. Note this 30-day timeline for reconsideration is different from the Rule §133.240 deadline for initial bill review, during which the carrier must pay, deny or *determine to audit* within 45 days of initial bill receipt. Rule §133.250 requires final action (pay or deny) within 30 days of receipt of the reconsideration request; however, auditing is not listed as an option during the reconsideration phase. Rule §133.230(a) prohibits a carrier from auditing a bill on which it has already taken final action (paid or denied).

   Review of the submitted information finds that upon initial bill review, the carrier took final action choosing to deny the bill. No information was presented to support an audit in accordance with Rule §133.230. Nor was any information presented to support utilization review within 45 days of carrier receipt of the initial medical bill. No documentation was presented to support an adverse determination in accordance with the requirements (including notice) regarding determinations of medical necessity. The respondent did not present any findings of a review organization related to the date of service.

The insurance carrier's denial reason "Based on the findings of a review organization" is unsupported.
The division concludes there are no unresolved issues of medical necessity. Accordingly, this dispute is eligible for review of the medical fee issues.

2. Upon initial bill review, the insurance carrier denied payment for the disputed compound with claim adjustment reason code 197 – Payment denied/reduced for absence of precertification/authorization."

   Rule §134.500(3) defines the division's closed formulary to include all available FDA approved drugs prescribed for outpatient use, with certain exclusions.

   Rule §134.530(b)(1) states explicitly that preauthorization is only required for

   - drugs identified with status N in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates
   - compounds containing a drug identified with status N in ODG Appendix A; and
   - any investigational or experimental drug.

   The disputed compound contains only FDA approved drugs not identified with status N in ODG Appendix A.
   Nor was any information presented to support that any component drugs were investigational or experimental.

   Whether a service is investigational or experimental must be determined on a case-by-case basis by utilization review — considering any special circumstances that require deviation from screening criteria or guidelines.[1] Utilization review includes a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of the health care.[2]

   Labor Code §408.021(a) entitles an injured employee to all health care required by the nature of the injury as and when needed, including health care that cures or relieves the effects of the injury; promotes recovery; or enhances the ability to return to or retain employment. This includes experimental and investigational services.

   In the adoption preamble to 28 Texas Administrative Code Chapter 19, Subchapter U, the division emphasized "an injured employee under both network and non-network coverage is entitled to all medically necessary health care services, including experimental and investigational health care services." [3]

   While investigational or experimental services require preauthorization, no service may be deemed investigational or experimental absent utilization review by a certified UR agent. The division states in the same preamble:

   > Even though the determination that a health care service is experimental or investigational does not in itself constitute an adverse determination, only a URA should make determinations that health care services are experimental or investigational, based on the definition of "utilization review." [3]

   Review of the submitted information finds no evidence to support a utilization review determination, considering the specific circumstances in this case, to establish the experimental or investigational nature of the compound.

   Because the respondent failed to support utilization review of the compound dispensed April 17, 2018, the disputed compound cannot be deemed experimental or investigational. Accordingly, authorization of the disputed compound was not required. As a consequence, the carrier's preauthorization denial is not supported.

   The disputed compound will therefore be reviewed for payment in accordance with division rules and fee guidelines.

3. 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.

[1] 28 Texas Administrative Code §19.2005(b)
[2] Texas Insurance Code §4201.002(13)
[3] ADOPTED RULES February 15, 2013, 38 *Texas Register* 895

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.

Conclusion

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	January 4, 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.

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.