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
Liberty Mutual Insurance Company

MFDR Tracking Number
M4-19-2213-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
December 17, 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: $245.50

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
June 16, 2018	Compound Medication Ingredients – Baclofen and Bupivacaine HCl	$245.50	$245.50

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 and denial of medical bills.
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. Texas Insurance Code, Chapter 19 sets out the requirements for utilization review.
5. The insurance carrier denied payment of the disputed compound based on medical necessity.

Issues

1. What service is considered in this dispute?
2. Is this dispute subject to dismissal based on medical necessity?
3. Is Memorial Compounding Pharmacy (Memorial) entitled to additional reimbursement?

Findings

1. Memorial is seeking additional reimbursement for a compound medication dispensed on June 16, 2018. Per submitted documentation, the compound in question consisted of the following:

Ingredients	Units	Billed Amount	Paid Amount
Gabapentin	3.6	$204.66	$204.66
Bupivacaine HCl	1.2	$54.72	$0.00
Amitriptyline HCl	1.8	$32.83	$32.83
Baclofen	5.4	$190.78	$0.00
Amantadine HCl	3.0	$72.69	$72.69

   Memorial is seeking reimbursement for the ingredients Bupivacaine HCl and Baclofen. These ingredients are considered in this dispute.

2. Per explanation of benefits dated July 11, 2018, the insurance carrier denied the disputed compound ingredients based on medical necessity, though the other billed ingredients were paid in full.

   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] The submitted documentation includes a report dated November 20, 2017, as support for utilization review of the compound in question. This document is not a review of the same compound considered in this dispute. The insurance carrier provided no evidence to support that it performed a utilization review of 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.

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

   The compound in question was billed by listing each drug included in the compound and calculating the charge for each drug separately.[5] Each disputed ingredient is listed below with its reimbursement amount.[6] 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
Bupivacaine HCl	38779052405	G	$45.60	1.2	$68.40	$54.72	$54.72
						Total	$245.50

   The total allowed amount for the ingredients in question is $245.50. This amount is recommended.

[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)(I)
[4] 28 Texas Administrative Codes §§134.240 and 19.2009
[5] 28 Texas Administrative Code §134.502(d)(2)
[6] 28 Texas Administrative Code §134.503(c)

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 $245.50.

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 $245.50, 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 29, 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.