



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

Indemnity Insurance Company of North America

MFDR Tracking Number

M4-18-1591-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

January 26, 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: \$726.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have been advised by the adjuster that the denials were not a question of preauthorization. The denial code should have been *Extent of Injury*, which we understand is in the dispute process at TDI. We have therefore updated the current EOB with the correct code."

Response Submitted by: myMatrixx

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 25, 2017	Pharmacy Service – Compound	\$726.61	\$726.61

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - Denied – Medication Not Authorized

Issues

1. Did the insurance carrier raise a new defense pursuant to 28 Texas Administrative Code §133.307?
2. Did the insurance carrier maintain its denial of the disputed compound based on preauthorization?
3. Is the requestor entitled to reimbursement for the disputed compound?

Findings

1. Memorial Compounding Pharmacy (Memorial) is seeking reimbursement for a compound dispensed on May 25, 2017. In its position statement, myMatrixx argued on behalf of Indemnity Insurance Company of North America, "The denial code should have been *Extent of Injury*, which we understand is in the dispute process at TDI."

The insurance carrier is required to address only those issues raised before the request for medical fee dispute resolution (MFDR) in its position statement.¹

Review of the submitted documentation finds that Indemnity Insurance Company of North America failed to present a denial based on the extent of the compensable injury to Memorial² before the date that a request for MFDR was filed.

If, in fact, the insurance carrier presented the denial based on extent of the compensable injury to Memorial prior to the date that the request for medical fee dispute resolution was submitted, the division notes that the insurance carrier failed to present this denial reason within 45 days from the date it received the complete medical bill.³

The division finds that this defense shall not be considered for review.

2. Indemnity Insurance Company of North America denied the disputed compound stating "Denied – Medication Not Authorized." In its position statement, myMatrixx advised that "the denials were not a question of preauthorization." Therefore, the division concludes that the insurance carrier did not maintain the basis of its denial for the disputed compound. The division will review the dispute based on applicable guidelines.
3. The division concludes that the insurance carrier's denial reasons are not supported. Consequently, the compound in question is eligible for reimbursement.

The health care provider 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:

Ingredient	NDC & Type	Price/ Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Flurbiprofen	38779036209 Generic	\$36.58	4.8 gm	\$219.48	\$175.58	\$175.58
Meloxicam	38779274601 Generic	\$194.67	0.18 gm	\$43.80	\$35.04	\$35.04
Cyclobenzaprine HCl	38779039509 Generic	\$46.332	1.8 gm	\$104.25	\$83.39	\$83.39
Tramadol HCl	38779237409 Generic	\$36.30	6.0 gm	\$272.25	\$217.80	\$217.80

¹ 28 Texas Administrative Code §133.307(d)(2)(F)

² 28 Texas Administrative Code §133.240

³ State Office of Risk Management v. Lawton, 295 S.W.3d 646 (Tex. 2009), <https://caselaw.findlaw.com/tx-supreme-court/1388209.html>

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

⁵ 28 Texas Administrative Code §134.503(c)

Ethoxy Diglycol	38779190301 Generic	\$0.342	3.0 ml	\$1.28	\$1.02	\$1.02
Bupivacaine HCl	38779052405 Generic	\$45.60	1.2 gm	\$68.40	\$54.72	\$54.72
Versapro Cream	38779252903 Brand Name	\$3.20	45.02 gm	\$157.03	\$144.06	\$144.06
Compounding Fee	NA	NA	NA	\$15.00	\$15.00	\$15.00
					Total	\$726.61

The total reimbursement is therefore \$726.61. 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 \$726.61.

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 \$726.61, 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 20, 2018
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.