



# 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**

M4-18-4210-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

July 3, 2018

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The above patient was prescribed medication and the carrier received and processed the bill."

**Amount in Dispute:** \$702.68

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The medications were determine not to be medically necessary based upon the retrospective review."

**Response Submitted by:** ESIS

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 11, 2017	Compound Medication	\$702.68	\$702.68

#### 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

- 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
- 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
- 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to certified networks.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 940

- 16 - Claim/service lacks information or has submission/billing error(s).
- W3 – Additional payment made on appeal/reconsideration.
- 5280 – No additional reimbursement allowed after review of appeal/reconsideration
- 5281 – Non covered services
- Notes: “The medical treatment was not authorized by the carrier”
- Notes: “Services not medically appropriate or necessary”

## Issues

1. Is this dispute subject to dismissal based on medical necessity?
2. Is the insurance carrier’s denial of payment based on billing errors supported?
3. Is the insurance carrier’s denial of payment based on preauthorization supported?
4. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the compound in question?

## Findings

1. Memorial is seeking reimbursement for a compound dispensed on October 11, 2017. ESIS argued on behalf of the insurance carrier that “The medications were determine not to be medically necessary based upon the retrospective review.” Per submitted explanation of benefits (EOB) dated November 2, 2017, the pharmacy bill was originally received by the insurance bill carrier on or about October 23, 2017. This EOB does not include a denial based on medical necessity.

An EOB dated April 11, 2018, denying the compound based on medical necessity is more than 45 days after the date the original complete bill was received.<sup>1</sup>

The insurance carrier has the obligation to dispute whether a treatment was medically necessary within 45 days after receiving a complete medical bill.<sup>2</sup> The DWC notes that the insurance carrier failed to provide evidence that a denial for medical necessity was presented to Memorial within 45 days from the date it received the complete pharmacy bill.

Therefore, the DWC finds that the dispute in question is not subject to dismissal based on this denial reason.

2. The insurance carrier denied the disputed compound, in part, with claim adjustment reason code 16, which indicates that the “claim/service lacks information or has submission/billing error(s).”

Review of the submitted pharmacy bills finds no submission or billing errors.<sup>3</sup> The insurance carrier failed to support this denial in its position statement.

3. 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<sup>4</sup>;
- any compound that contains a drug identified with a status of “N” in the current edition of the ODG Appendix A; and
- any investigational or experimental drug.<sup>5</sup>

The compound in question does not contain an ingredient identified with a status of “N” in the current edition of the ODG, Appendix A.

The determination of a service’s investigational or experimental nature is determined on a case by case basis through utilization review.<sup>6</sup> ESIS provided no evidence that the insurance carrier engaged in a prospective or

<sup>1</sup> 28 Texas Administrative Code §133.240(a)

<sup>2</sup> “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 S.W.3d 646 (Tex. 2009), <https://caselaw.findlaw.com/tx-supreme-court/1388209.html>

<sup>3</sup> 28 Texas Administrative Code §133.10(f)(3)

<sup>4</sup> ODG Treatment in Workers’ Comp (ODG) / Appendix A, ODG Workers’ Compensation Drug Formulary

<sup>5</sup> 28 Texas Administrative Code §134.530(b)(1)

<sup>6</sup> Texas Insurance Code §19.2005(b)

retrospective utilization review to establish that the specific compound considered in this review is investigational or experimental.

Because the insurance carrier failed to perform utilization review on the disputed compound to evaluate a premise that the compound is investigational or experimental, the requirement for preauthorization for this reason is not triggered in this case. The insurance carrier’s preauthorization denial is therefore not supported.

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

The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately.<sup>7</sup> Each ingredient is listed below with its reimbursement amount.<sup>8</sup> 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
						<b>Total</b>	<b>\$702.68</b>

5. The total reimbursement is therefore \$702.68. 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 \$702.68.

***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 \$702.68, 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

December 18, 2018  
\_\_\_\_\_  
Date

<sup>7</sup> 28 Texas Administrative Code §134.502(d)(2)

<sup>8</sup> 28 Texas Administrative Code §134.503(c)

### ***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.**