



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 Flood Control District

MFDR Tracking Number

M4-18-4810-01

Carrier's Austin Representative

Box Number 21

MFDR Date Received

August 7, 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: \$583.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "... the medications were determined not medically necessary upon retrospective review to treat the compensable injury."

Response Submitted by: Thornton, Biechlin, Reynolds & Guerra

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 10, 2017	Compound Medication	\$583.89	\$583.89

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 §19.2009 sets out the requirements for notice of determinations made in utilization review.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - Notes: "Denied Per Retrospective Peer Review Determination"

- 216 – Based on the findings of a review organization.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

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

Findings

1. Memorial is seeking reimbursement for a compound dispensed on December 10, 2017. Per explanations of benefits dated January 3 and 9, 2018, the insurance carrier denied the disputed compound based on an adverse determination of 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 an adverse determination of medical necessity, including giving the health care provider – in this case, Memorial – an opportunity to discuss the treatment in question.²

Thornton, Biechlin, Reynolds & Guerra submitted a document on behalf of Harris County Flood Control District, dated May 10, 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 addressing the compound in question as Thornton, Biechlin, Reynolds & Guerra provided no evidence that Memorial was given an opportunity to discuss the compound prior to the insurance carrier’s denial based on an adverse determination of 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 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.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
Flurbiprofen	38779036209	G	\$36.58	6	\$274.35	\$219.48	\$219.48
Meloxicam	38779274601	G	\$194.67	0.18	\$43.80	\$35.04	\$35.04
Mefenamic Acid	38779066906	G	\$123.60	1.8	\$278.10	\$222.48	\$222.48
Baclofen	38779038809	G	\$35.63	3	\$133.61	\$106.89	\$106.89
						Total	\$583.89

Memorial is seeking reimbursement of \$583.89. This amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been 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 \$583.89.

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 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 \$583.89, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	_____ Laurie Garnes _____	_____ November 14, 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.