



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

Graphic Arts Mutual Insurance Company

MFDR Tracking Number

M4-18-5009-01

Carrier's Austin Representative

Box Number 1

MFDR Date Received

August 16, 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: \$726.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The treatment associated with these charges was non certified by Genex utilization review as not reasonable or necessary and therefore not owed by a workers' compensation carrier."

Response Submitted by: Utica National Insurance Group

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: January 29, 2018, Compound Medication, \$726.62, \$726.62

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 or denial of a medical bill.
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. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
5. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
6. 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to certified networks.
7. 28 Texas Administrative Code, Chapter 19 sets out the requirements for utilization review.

8. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 216 – Based on the findings of a review organization.
 - 29 – Services denied at the time authorization/pre-certification was requested.
 - 50 – These are non-covered services because this is not deemed a medical necessity by the payer.
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - Notes: “NO ADDITIONAL PAYMENT RECOMMENDED”

Issues

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

Findings

1. Memorial is seeking reimbursement for a compound dispensed on January 29, 2018. The compound in question contained the following ingredients:

- Meloxicam
- Flurbiprofen
- Tramadol HCl
- Cyclobenzaprine HCl
- Bupivacaine HCl
- Ethoxy Diglycol
- Versapro Cream

The insurance carrier denied the disputed compound based on medical necessity as determined by a review organization.

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

Utica National Insurance Group submitted a document on behalf of Graphic Arts Mutual Insurance Company, dated November 9, 2017, to support its denial of the disputed compound. The division finds that the submitted document does not support that the insurance carrier performed a utilization review for the compound ingredients in question as Utica National Insurance Group provided no evidence that Memorial was given an opportunity to discuss the compound prior to the insurance carrier’s denial based on medical necessity.³

The division concludes that this dispute is not subject to dismissal based on medical necessity.

2. The insurance carrier denied the disputed compound based on preauthorization. Preauthorization for compounds is only required for:
 - any compound that contains a drug identified with a status of “N” in the current edition of the ODG Appendix A⁴; and
 - any investigational or experimental drug.⁵

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

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 *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary*

⁵ 28 Texas Administrative Code §134.540(b)

The determination of a service’s investigational or experimental nature is determined on a case by case basis through utilization review.⁶ The insurance carrier provided no evidence that it engaged in a prospective or retrospective utilization review to establish that the specific compound considered in this review is investigational or experimental.

The insurance carrier’s preauthorization denial is therefore not supported.

- Because the insurance carrier failed to support its denial of reimbursement, Memorial is entitled to reimbursement in accordance with applicable rules and laws.

The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately.⁷ Each ingredient is listed below with its reimbursement amount.⁸ 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
Meloxicam	38779274601	G	\$194.67	0.18	\$43.80	\$35.04	\$35.04
Flurbiprofen	38779036209	G	\$36.58	4.8	\$219.48	\$175.58	\$175.58
Tramadol	38779237409	G	\$36.30	6	\$272.25	\$217.80	\$217.80
Cyclobenzaprine	38779039509	G	\$46.33	1.8	\$104.24	\$83.39	\$83.39
Bupivacaine	38779052405	G	\$45.60	1.2	\$68.40	\$54.72	\$54.72
Ethoxy Diglycol	38779190301	G	\$0.34	3	\$1.28	\$1.03	\$1.03
Versapro Cream	38779252903	B	\$3.20	45.02	\$157.03	\$144.06	\$144.06
Fee	NA	NA	NA	NA	\$15.00	\$15.00	\$15.00
						Total	\$726.62

The total allowable reimbursement for the compound in dispute is \$726.62. 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 \$726.62.

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 \$726.62, 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

November 1, 2018
Date

⁶ Texas Insurance Code §19.2005(b)

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

⁸ 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.