



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

TASB Risk Management Fund

MFDR Tracking Number

M4-18-5224-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

August 27, 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: \$555.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It was processed ... and denied based on peer review findings and for exceeding Official Disability Guidelines (ODG) ... Per the peer review dated 07/08/2017, it is indicated that any prescribed medications are being utilized for non-work related conditions as the compensable injuries have been resolved."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: January 30, 2018, Pharmaceutical Compound, \$555.68, \$555.68

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 (DWC).

Background

- 1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to certified networks.

5. The insurance carrier denied payment based on the following claim adjustment reason codes:
  - 55 – Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
  - 216 – Based on the findings of a review organization.
  - 197 – Payment adjusted for absence of precertification/authorization
  - 114 – Procedure/product not approved by the Food and Drug Administration.
  - Notes: “Per Rule 134.530 Pre-auth is required for any drug identified as investigational or experimental for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined by labor code 413.014. The compound product is not used in an approved FDA form & not approved by the FDA.”
  - Notes: “Peer review by Dr. Richard A. Lutz, DO on file.”
  - Notes: “Per Rule 137.600 treatment provided on or after May 1, 2007 must in accordance with the Official Disability Guidelines.”

### **Issues**

1. Did the insurance carrier raise a new defense in its response?
2. Is this dispute subject to dismissal based on medical necessity?
3. Is the insurance carrier’s reason for denial of payment 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 January 30, 2018. In its position statement, TASB Risk Management Fund (TASB), on behalf of the insurance carrier, argued that “any prescribed medications are being utilized for non-work related conditions as the compensable injuries have been resolved.”

The response from the insurance carrier is required to address only the denial reasons presented to the requestor the request for medical fee dispute resolution (MFDR) was filed with the Texas Department of Insurance, Division of Workers’ Compensation (DWC). Any new denial reasons or defenses raised shall not be considered in this review.<sup>1</sup>

The submitted documentation does not support that a denial based on relatedness was provided to Memorial before this request for MFDR was filed. Therefore, the DWC will not consider this argument in the current dispute review.

2. TASB denied the disputed compound ingredients, in part, based on medical necessity.

If a dispute regarding medical necessity exists, the medical necessity dispute must be resolved prior to a request for medical fee dispute resolution.<sup>2</sup> A medical necessity denial of a medical bill must be based on an adverse determination by a utilization review agent.<sup>3</sup>

The submitted documentation includes a report dated July 8, 2017, as support for utilization review of the disputed compound. This report does not support that the insurance carrier performed a utilization review of the drug in question for the following reasons<sup>4</sup>:

- The document does not indicate or support that the health care provider – in this case, Memorial Compounding Pharmacy – was notified of the utilization review findings, or that Memorial was afforded a reasonable opportunity to discuss the billed compound,

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<sup>1</sup> 28 Texas Administrative Code §133.307(d)(2)(F)

<sup>2</sup> 28 Texas Administrative Code §133.305(b)

<sup>3</sup> 28 Texas Administrative Code §133.240(q), 28 Texas Administrative Codes §§19.2009 and 19.2010

<sup>4</sup> 28 Texas Administrative Code §19.2009(b)

- The document does not include a description for filing a complaint with the Texas Department of Insurance,
- The document does not include information describing the processes for filing an appeal,
- The document itself includes the statement, “In and of itself, this opinion does not constitute a recommendation for specific claims or administrative functions to be made or enforced.”

For these reasons, the insurance carrier’s denial is not sufficiently supported. This dispute is not subject to dismissal based on medical necessity.

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>5</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>6</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.

TASB argued that “Claim/service denied because procedure/treatment is deemed experimental/ investigational by the payer.”

The determination of a service’s investigational or experimental nature is determined on a case by case basis through utilization review.<sup>7</sup> Utilization review, includes a prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services.<sup>8</sup>

TASB provided no evidence that the insurance carrier engaged in a prospective or 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, the requirement for preauthorization based on a premise that the compound is investigational or experimental 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>9</sup> Each ingredient is listed below with its reimbursement amount.<sup>10</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
						<b>Total</b>	<b>\$555.68</b>

The total reimbursement is therefore \$555.68. This amount is recommended.

<sup>5</sup> ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary

<sup>6</sup> 28 Texas Administrative Code §134.530(b)(1)

<sup>7</sup> Texas Insurance Code §19.2005(b)

<sup>8</sup> Texas Insurance Code §4201.002(13)

<sup>9</sup> 28 Texas Administrative Code §134.502(d)(2)

<sup>10</sup> 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 \$555.68.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor \$555.68, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

	Laurie Garnes	April 23, 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 DWC 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.**