TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
Hartford Insurance Company

MFDR Tracking Number
M4-16-1268-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
January 13, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached bills were denied by the carrier stating preauthorization was not obtained. Reconsideration was submitted but denied. We are now requesting Medical Fee Dispute Resolution."

Amount in Dispute: $495.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Division Rule 133.307 governs the resolution of medical fee disputes. Subsection (C)(2)(O) requires a requestor to document, demonstrate and justify that the payment amount being sought is a fair and reasonable rate of reimbursement when a dispute involves healthcare for which the Division has not established a reimbursement rate. This case concerns the prescription of compound drugs. There is no rate established by the Division for the drug compound at issue in this case. Accordingly, Memorial Compounding was required to provide documentation in justifying the amount of reimbursement being sought in this case. It is has failed to do so.

Response submitted by: Burns Anderson Jury & Brenner, L.L.P

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 14, 2015	Pharmacy Services	$495.44	$495.44

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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the reimbursement guidelines for pharmaceutical services.
3. The services in dispute were denied with the following rejection/denial codes.

- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline
- 791 – This item is reimbursed as a brand-name prescribed drug
- 91 – Dispensing fee adjustment
- D20 – Previously denied by adjuster with PBM
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 131 – Claim specific negotiated discount
- 197 – Recommended allowance based on negotiated discount/rate

Issues

1. Is the respondents' position statement supported?
2. Is the carriers' reduction code supported?
3. What is the maximum allowable reimbursement?
4. Is the requestor due additional payment?

Findings

1. The respondent states in pertinent part, "This case concerns the prescription of compound drugs. There is no rate established by the Division for the drug compound at issue in this case." 28 Texas Administrative Code §134.503 (c) states in relevant part,

> The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
>
> (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
>
> (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
>
> (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;
>
> (C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection;

Review of the submitted DWC066 finds the following;

- Mefenamic Acid
- Baclofen
- Fluribiprofen
- Meloxicam

The Division finds a fee guideline or rate does exist for the services in dispute. Therefore, the respondents' position is not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.

2. The carrier reduced the services in dispute with the following reason codes, P12 – "Workers' compensation jurisdictional fee schedule adjustment." Review of the submitted Explanation of Benefits finds "0" allowed or paid. As stated above a Division recommended fee calculation is available. The carriers' reduction is not supported.

   The denial code, D20 – "Previously denied by adjuster with PBM" was also used by the carrier. Insufficient evidence was found to support a denial by an adjuster. Therefore, this denial will not be considered.

   The denial codes 131 – "Claim specific negotiated discount" and 197 – "Recommended allowance based on negotiated discount/rate" was used by the carrier for the dates of service in dispute. Insufficient evidence was found to support the presence of any negotiated discount and or rates. Therefore, this denial will not be considered.

3. Pursuant to provisions of Rule 134.503(c)(1), the maximum allowable reimbursement will be calculated as follows:

Date of service	Name of Medication	Reported units	MAR (AWP per unit) x (number of units) x 1.25 +$4.00
August 14, 2015	Mefenamic Acid	1.8	$123.60000 x 2 x 1.25 + $4.00 = $313.00
August 14, 2015	Baclofen Powder	3	$35.63000 x 3 x 1.25 + $4.00 = $137.61
August 14, 2015	Flurbiprofen	6	$36.58000 x 6 x 1.25 + $4.00 = $278.35
August 14, 2015	Meloxicam	1	$194.67000 x 1 x 1.25 + $4.00 = $247.34

4. Based on the submitted DWC066, Box 21, the Generic NDC is for **bulk powder**. The total allowed amount is $976.30. The requestor is seeking $495.44, 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 $495.44.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $495.44 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February , 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §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 with the Division. **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.