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 RX

Respondent Name
Hartford Fire Insurance Co

MFDR Tracking Number
M4-16-2439-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
April 14, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached bill was denied by the carrier."

Amount in Dispute: $489.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Bupivacaine is not on the formulary list; hence, it is not a "Y" drug and requires authorization. Compound medications are also not indicated for this diagnosis in the State Guides, and treatment not in accordance with those guides would need prior authorization."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 2, 2015	Baclofen, Amantadine, Gabapentin, Amitriptyline, Bupivacaine HCL	$489.96	$489.96

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 §134.530 sets out the requirements for use of the closed formulary for claims not subject to certified networks.
3. 28 Texas Administrative Code §134.503 sets out the reimbursement guidelines for pharmacy services not subject to a certified network.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 75 – Prior authorization required

Issues

1. Is the carrier's preauthorization denial supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code, 75 - "Prior authorization required." 28 Texas Administrative Code §134.503 (b)(1) states in pertinent part,

> Preauthorization is only required for:
>
> (A) drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates;
>
> (B) any compound that contains a drug identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates; and
>
> (C) any investigational or experimental drug 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 in Labor Code §413.014(a).

The service in dispute is a compound medication containing Baclofen, Amantadine HCL, Gabapentin USP, Amityriptyline HCL, and Bupivicaine HCL, therefore §134.503(b)(1)(B) applies.

Review of Appendix A of the ODG Workers' Compensation Drug Formulary finds:

- none of the services in dispute are listed as a "N" drug; and
- while Bupivicaine HCL is not found on the Appendix A, Drug Formulary, it is also not found to be investigational or experimental based on search of the Food and Drug Administration web site at, http://www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm

The division concludes that preauthorization was not required for service in dispute. For that reason, the division finds the carrier's preauthorization denial is not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code §134.503(c) states,

> 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;

The maximum allowable reimbursement will be calculated as follows:

Date of Service	Service in Dispute	Quantity	Amount Billed	MAR ((AWP per unit) x (number of units) x 1.25) + $4.00
June 2, 2015	Gabapentin	4	$188.10	$59.85000 x 4 x 1.25 + $4.00 = $303.25

June 2, 2015	Bupivicaine	1	$48.02	$45.60000 x 1 x 1.25 + $4.00 = $61.00
June 2, 2015	Baclofen	5	$184.68	$35.63000 x 5 x 1.25 + $4.00 = $226.69
June 2, 2015	Amantadine	3	$38.46	$24.22500 x 3 x 1.25 + $4.00 = $94.84
June 2, 2015	Amitriptyline	2	$30.70	$18.24000 x 2 x 1.25 + $4.00 = $49.60
		Total	$489.96	$735.58

3. The maximum allowable for the services in dispute is $735.58. The requestor is seeking $489.96. 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 $489.96.

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 $489.96 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		May , 2016
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 28 Texas Administrative Code §133.307, 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.