



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 RX

Respondent Name

TRUMBULL INSURANCE CO

MFDR Tracking Number

M4-16-3507-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

July 22, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These medications do not require preauthorization and are to be retrospective review."

Amount in Dispute: \$967.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Compounds are considered off label as many ingredients are not FDA approved for topical used, thus, it would be considered 'experimental and investigational'. Request must be submitted for Utilization Review prior to authorization as allowed by 14 TIC §4201.002(13)."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 8, 2015	Compound Medication	\$477.24	\$477.24
January 25, 2016	Compound Medication	\$489.96	\$489.96
Total		\$967.20	\$967.20

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

- 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 Codes §§134.530 and 134.540 sets out the closed formulary requirements, effective January 17, 2011, 35 TexReg 11344.
- The insurance carrier denied payment based on the absence of preauthorization.

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the compound in question?

Findings

1. Memorial is seeking reimbursement for compounds dispensed on December 8, 2015, and January 25, 2016. The insurance carrier denied the disputed compounds based on preauthorization. Preauthorization is only required for:
 - drugs identified with a status of "N" in the current edition of the ODG Appendix A¹;
 - 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.²

The Hartford, on behalf of the insurance carrier, argued that "Compounds are considered off label as many ingredients are not FDA approved for topical used, thus, it would be considered 'experimental and investigational'. Request must be submitted for Utilization Review prior to authorization as allowed by 14 TIC §4201.002(13)."

The determination of a service's investigational or experimental nature is determined on a case by case basis through utilization review.³ Utilization review, includes a prospective, concurrent, or **retrospective review to determine the experimental or investigational nature** of health care services.⁴

The preamble relating to the adoption of relevant pharmacy rules clearly states that the DWC intended for the **ingredients** of the compound to drive preauthorization requirements, not compounds as a class.⁵ The compounds in question do not contain an ingredient identified with a status of "N" in the current edition of the ODG, Appendix A.

The Hartford provided **no evidence** that the insurance carrier engaged in a prospective or retrospective utilization review to establish that the specific compounds considered in this review are 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.

2. Because the insurance carrier failed to sufficiently support its denial of reimbursement, Memorial is entitled to reimbursement.

The compounds in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately.⁶ Each ingredient is listed below with its reimbursement amount.⁷ The calculation of the total allowable amount is as follows:

¹ *ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary*

² 28 Texas Administrative Codes §§134.530 (b)(1) 134.540 (b)

³ Texas Insurance Code §19.2005 (b)

⁴ Texas Insurance Code §4201.002 (13)

⁵ The Division initially considered requiring preauthorization for all compound drugs. However, with stakeholder feedback and, in the interest of curbing the expense of numerous preauthorization requests, the Division reconsidered and adopts a more measured approach as specified in the proposal, which is requiring preauthorization only for those compounds that contain an "N" drug. The Division notes that an insurance carrier has the ability to conduct retrospective utilization review for all compounds not containing an "N" drug so that insurance carriers have the ability to only pay for medically necessary care.

[http://texreg.sos.state.tx.us/public/regviewer\\$ext.RegPage?sl=T&app=2&p_dir=F&p_rloc=231643&p_tloc=98652&p_ploc=78924&pg=6&p_reg=201006879&ti=&pt=&ch=&rl=&z_chk=53523](http://texreg.sos.state.tx.us/public/regviewer$ext.RegPage?sl=T&app=2&p_dir=F&p_rloc=231643&p_tloc=98652&p_ploc=78924&pg=6&p_reg=201006879&ti=&pt=&ch=&rl=&z_chk=53523)

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

⁷ 28 Texas Administrative Code §134.503(c)

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Gabapentin	38779246109	G	\$59.85	3	\$224.44	\$156.75	\$156.75
Amitriptyline	38779018904	G	\$18.24	2.4	\$54.72	\$42.17	\$42.17
Amantadine	38779041105	G	\$24.23	4.8	\$145.38	\$61.58	\$61.58
Flurbiprofen	38779036209	G	\$36.58	4.8	\$219.48	\$168.72	\$168.72
Bupivacaine	38779052405	G	\$45.60	1.2	\$68.40	\$48.02	\$48.02
						Total	\$477.24

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	\$184.68	\$184.68
Amantadine	38779041105	G	\$24.23	3	\$90.84	\$38.46	\$38.46
Gabapentin	38779246109	G	\$59.85	3.6	\$269.33	\$188.10	\$188.10
Amitriptyline	38779018904	G	\$18.24	1.8	\$41.04	\$30.70	\$30.70
Bupivacaine	38779052405	G	\$45.60	1.2	\$68.40	\$48.02	\$48.02
						Total	\$489.96

The total reimbursement is therefore \$967.20. This amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$967.20.

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 \$967.20, 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

Date

July 30, 2020

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 DWC 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.