



# 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**

Westrock MWV LLC

**MFDR Tracking Number**

M4-18-0954-01

**Carrier's Austin Representative**

Box Number 55

**MFDR Date Received**

December 6, 2017

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "These medications do not require preauthorization therefore do not need a retrospective review."

**Amount in Dispute:** \$566.53

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "For the prescriptions for date of service on July 27, 2017, the provider submitted bills in the amount of \$566.53. The Carrier reduced the amount to be paid for the prescriptions to \$453.48. The reduction is based on DWC Fee Guidelines ... The Carrier believes that it has reimbursed the provider for the medical services rendered as required under the DWC's Fee Guidelines, statute and rules."

**Response Submitted by:** Christopher J. Ameel, PLLC

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 27, 2017	Pharmacy Service – Compound	\$566.53	\$35.04

#### 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 of the closed formulary for claims not subject to certified networks.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - P13 – Payment reduced or denied based on workers’ compensation jurisdictional regulations or payment policies...
  - P12 – Workers’ compensation jurisdictional fee schedule adjustment.
  - 01(P12) The charge for the procedure exceeds the amount indicated in the fee schedule.
  - HE75 – Prior Authorization Required

### Issues

1. What compound ingredients are considered in this dispute?
2. Did Memorial Compounding Pharmacy (Memorial) support the billed amount sought for the compound ingredient Tramadol HCl?
3. Did Westrock MWV support its denial of the compound ingredient Meloxicam?
4. Is Memorial entitled to additional reimbursement?

### Findings

1. Memorial is seeking reimbursement for a compound dispensed on July 27, 2017, containing the following ingredients:
  - Meloxicam, NDC 38779274601, \$35.04
  - Flurbiprofen, NDC 38779036209, \$175.58
  - Tramadol HCl, NDC 38779237409, \$217.80
  - Cyclobenzaprine HCl, NDC 38779039509, \$83.39
  - Bupivacaine HCl, NDC 38779052405, \$54.72

Per Explanation of Benefits submitted by Memorial and dated September 9, 2017, the insurance carrier reimbursed Memorial in full for Flurbiprofen, Cyclobenzaprine HCl, and Bupivacaine HCl. Therefore, these ingredients will not be considered in this fee dispute.

The insurance carrier reduced the billed amount of the ingredient Tramadol HCl and denied payment for the ingredient Meloxicam. These ingredients will be reviewed in accordance to applicable pharmaceutical rules.

2. The insurance carrier reduced the billed amount of the compound ingredient Tramadol HCl to a total payment of \$139.79, citing the workers’ compensation fee schedule as its reason for the reduction. 28 TAC §134.503(c) applies and states, in pertinent part, that the insurance carrier shall reimburse the lesser of: (1) the fee established by the division’s applicable formula 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; or (2) the amount billed to the insurance carrier.

Memorial has the burden to support its requested amount. In its position statement, Memorial did not demonstrate how it arrived at the requested amount or whether that amount is consistent with the methodology under 28 TAC §134.503(c). After notification by the division’s medical fee dispute resolution program of the carrier’s response and payment, Memorial did not take the opportunity to refute the carrier’s payment calculation. The division concludes that Memorial failed to support the billed amount sought for Tramadol HCl. For this reason, no additional reimbursement is recommended.

3. The insurance carrier denied the compound ingredient Meloxicam with claim adjustment reason code HE75 – “Prior Authorization Required.”

28 Texas Administrative Code §134.530(b)(2) states that preauthorization is **only** required for:

- 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;
- 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

- 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 division finds that Meloxicam, NDC 38779274601 is not identified with a status of “N” in the current edition of the ODG, *Appendix A*. The insurance carrier failed to articulate any arguments to support its denial for preauthorization. Therefore, the division concludes that the compound ingredient in question did not require preauthorization and the insurance carrier’s denial of payment for this reason is not supported.

4. Because the insurance carrier failed to support its denial of payment, Meloxicam as presented in this dispute is eligible for reimbursement as follows:

28 TAC §134.503 states, in pertinent part:

- (c) 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:  $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.25) + \$4.00$  dispensing fee per prescription = reimbursement amount;
    - (B) Brand name drugs:  $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.09) + \$4.00$  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; or
  - (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
    - (A) health care provider; or
    - (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

The division finds that the reimbursement for the disputed ingredient is calculated as follows:

- Meloxicam bulk powder  $194.67 \times 0.18 \times 1.25 = \$43.80$

The total allowable reimbursement amount is \$43.80. Memorial is seeking \$35.04 for this ingredient. An additional reimbursement of \$35.04 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 \$35.04.

### ***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 \$35.04, 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	May 14, 2018 Date
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### ***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.**