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
M4-18-1183-01

Carrier's Austin Representative
Box Number 55

MFDR Date Received
December 20, 2017

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $566.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier would show that for the five prescriptions filled on June 28, 2017 in the amount of $566.53, according to the DWC-62, the providers were paid $531.49, an amount that was less than that charged amount, 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
June 28, 2017	Pharmacy Services - 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 base on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable.
   - HE75 – Prior Authorization Required

Issues

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

Findings

1. Memorial is seeking reimbursement of $566.53 for a compound dispensed on June 28, 2017. The compound in question consists of the following ingredients:

   - Meloxicam, $35.04
   - Flurbiprofen, $175.58
   - Tramadol HCl, $217.80
   - Cyclobenzaprine HCl, $83.39
   - Bupivacaine HCl, $54.72

   Per Explanation of Benefits submitted by Memorial and dated November 11, 2017, the insurance carrier reimbursed Memorial in full for Flurbiprofen, Tramadol HCl, Cyclobenzaprine HCl, and Bupivacaine HCl. Therefore, these ingredients will not be considered in this fee dispute.

   The insurance carrier denied payment for the ingredient Meloxicam. This ingredient will be reviewed in accordance to applicable pharmaceutical rules.

   The insurance carrier denied the disputed compound 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 the compound in question does not include a drug 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 in question did not require preauthorization and the insurance carrier's denial of payment for this reason is not supported. Therefore, the ingredient in question will be reviewed for reimbursement.

2. 28 Texas Administrative Code §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 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; 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 drugs is calculated as follows:

- Meloxicam bulk powder 194.67 x 0.18 x 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

	Laurie Garnes	February 14, 2018
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 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.