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
M4-18-1438-01

Carrier's Austin Representative
Box Number 55

MFDR Date Received
January 17, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the reconsideration based on **PARTIAL PAYMENT** … After reviewing the explanation of benefits it indicates that carrier paid $453.48 and not the full amount of **$566.53**. This claim should be processed with the full amount billed as per **Administrative Labor Code 134.503**(c)."

Amount in Dispute: $566.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 15, 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. Did Westrock MWV, LLC respond to the medical fee dispute?
2. What compound ingredients are considered in this dispute?
3. Did Memorial Compounding Pharmacy (Memorial) support the billed amount sought for the compound ingredient Tramadol HCl?
4. Did Westrock Mwv support its denial of the compound ingredient Meloxicam?
5. Is Memorial entitled to additional reimbursement?

Findings

1. The Austin carrier representative for Westrock MWV, LLC is Christopher Ameel, Attorney at Law. The insurance carrier's representative acknowledged receipt of the copy of this medical fee dispute on January 26, 2018. 28 Texas Administrative Code §133.307 states, in relevant part:

   (d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
   (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

   Review of the documentation finds that no response has been received on behalf of Westrock MWV, LLC from the Christopher Ameel, Attorney at Law to date. The division concludes that Westrock MWV, LLC failed to respond within the timeframe required by §133.307(d)(1). For that reason the division will base its decision on the information available.

2. Memorial is seeking reimbursement for a compound dispensed on August 15, 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 29, 2017, the insurance carrier reimbursed Memorial in full for Cyclobenzaprine HCl, Bupivacaine HCl, and Flurbiprofen. 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.

3. 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). Memorial did not take the opportunity to refute the carrier's payment calculation as presented on its explanation of benefits. The division concludes that Memorial failed

to support the billed amount sought for Tramadol HCl. For this reason, no additional reimbursement is recommended.

4. 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.

5. 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 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 ingredient 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

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. 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	May 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.