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 Pharmacy

Respondent Name
Hartford Accident & Indemnity Company

MFDR Tracking Number
M4-18-2286-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
February 27, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the **original bill** as well and the reconsideration based on **NOT APPROVED PROVIDER**."

Amount in Dispute: $566.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Overall Decision on the case is Non-Certified."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 26, 2017	Pharmacy Service – Compound	$566.53	$566.53

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 §134.502 sets out procedures for pharmaceutical services.
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:
   - 71 – Prescriber is not covered
   - N26 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

Issues

1. Did Hartford Accident & Indemnity Company (Hartford) raise a new defense pursuant to 28 Texas Administrative Code §133.307?
2. Did Hartford support its denial of payment for the compound in question based on a non-covered provider?
3. Did Hartford support its denial of payment for the compound in question based on a lack of information?
4. Is Memorial Compounding Pharmacy (Memorial) eligible for reimbursement of the disputed compound?

Findings

1. Memorial is seeking reimbursement for a compound dispensed on July 26, 2017. In its position statement, Hartford argued, "the requested CMPD: meloxicam, flurbiprofen, tramadol, cyclobenzaprine, bupivacaine; quantity 14 for 5 day supply, refills 0 is non-certified."

   28 Texas Administrative Code §133.307(d)(2)(F) states, in relevant part, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   Review of the submitted documentation finds that Hartford failed to present a medical necessity denial to Memorial in accordance with 28 Texas Administrative Code §133.240 prior to the date the request for medical fee dispute resolution (MFDR) was filed. The division concludes that this defense presented in Hartford's position statement shall not be considered for review because this assertion constitutes a new defense pursuant to 28 Texas Administrative Code §133.307(d)(2)(F).

2. Hartford denied the compound in question, in part, with claim adjustment reason code 71, indicating the prescriber is not covered. Review of the submitted documentation failed to support that Memorial Compounding Pharmacy is not a covered provider. For this reason, the division finds that this denial reason is not supported.

3. Hartford also denied the disputed compound, in part, with claim adjustment reason code N26 – "Claim/service lacks information or has submission/billing error(s) which is needed for adjudication." Hartford's response documentation included a form dated August 4, 2017 requesting information about how the medication was related to the compensable injury.

   28 Texas Administrative Code §134.502(e) states,

   > The insurance carrier, injured employee, or pharmacist may request a statement of medical necessity from the prescribing doctor. If an insurance carrier requests a statement of medical necessity, the insurance carrier shall provide the sender of the bill a copy of the request at the time the request is made. **An insurance carrier shall not request a statement of medical necessity unless in the absence of such a statement the insurance carrier could reasonably support a denial based upon extent of, or relatedness to the compensable injury, or based upon an adverse determination** [emphasis added].

   The documentation submitted to the division failed to demonstrate that Hartford raised an issue of extent of, or relatedness to the compensable injury, or an adverse determination. Therefore, the division finds that this denial is not supported.

4. 28 Texas Administrative Code §134.503 applies to the compounds in dispute and 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 compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately as required by 28 Texas Administrative Code §134.502(d)(2). Each ingredient is listed below with its corresponding reimbursement amount as applicable.

Ingredient	NDC & Type	Price/ Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Meloxicam	38779274601 Generic	$194.67	0.18 gm	$43.80	$35.04	$35.04
Flurbiprofen	38779036209 Generic	$36.58	4.8 gm	$219.48	$175.58	$175.58
Tramadol HCl	38779237409 Generic	$36.30	6.0 gm	$272.25	$217.80	$217.80
Cyclobenzaprine HCl	38779039509 Generic	$46.332	1.8 gm	$104.25	$83.39	$83.39
Bupivacaine HCl	38779052405 Generic	$45.60	1.2 gm	$68.40	$54.72	$54.72
					Total	$566.53

The total reimbursement is therefore $566.53. 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 $566.53.

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 $566.53, 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 3, 2018 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.