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
State Office of Risk Management

MFDR Tracking Number
M4-18-2508-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
March 12, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Texas Labor Code Section 408.027 (b) requires that the carrier must pay, reduce, deny or determine to audit the health provider's claim no later than the 45th day after the date of receipt by the carrier. Memorial did not receive any correspondence as per Rule..."

Amount in Dispute: $489.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon notification of this dispute the Office performed a review of the medical billing received from Memorial Compounding, where we determined that the audit has been denied in error. Out of good faith, the Office will submit a request for reconsideration to have this bill audited in accordance with 28 TAC Rule §134.530."

Response Submitted by: State Office of Risk Managment

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 26, 2017	Tramadol 100%	$489.98	$489.98

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 the procedures for pharmaceutical benefits.
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:
   - 293 – This procedure requires prior authorization and none was identified

Issues

1. Is the carrier's reason for denial of payment supported?
2. Is the requestor entitled to reimbursement for the medication in question?

Findings

1. The requestor is seeking reimbursement of $489.98 for a medication dispensed on July 26, 2017. The carrier denied the disputed compound with claim adjustment reason code 293 – "This procedure requires prior authorization and none was identified."

   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 named medication by NDC code in question is not a drug identified with a status of "N" in the current edition of the ODG, *Appendix A*. Therefore, the division concludes that the medication in question did not require preauthorization and the carrier's denial of payment for this reason is not supported. Therefore, the disputed medication will be reviewed for reimbursement.

2. 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;

   The medication in dispute was billed with NDC 38779-2374-09, Tramadol HCl (Bulk) Powder as required by 28 Texas Administrative Code §134.502(d)(2) and the MAR is calculated as follows:

Medication	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)
Tramadol	38779237409	$36.30	60	$2,722.50	$489.98	$489.98
					Total	$489.98

The total reimbursement is $489.98. 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 $489.98.

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 $489.98, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		July 27, 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.