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
Hartford Insurance Company of Midwest

MFDR Tracking Number
M4-18-2788-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
April 2, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial Compounding Pharmacy has met the requirements to receive reimbursement."

Amount in Dispute: $583.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It appears Memorial Compounding did not see Hartford's reconsideration EOB evidencing payment."

Response Submitted by: Burns Anderson Jury & Brenner, L.L.P.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 14, 2017	Compound Medication	$583.89	$329.37

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 (DWC).

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. 28 Texas Administrative Codes §§134.530 and 134.540 set out the guidelines for preauthorization of pharmaceutical services.
5. The insurance carrier reduced payment for the disputed compound based on preauthorization.

Issues

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

Findings

Memorial is seeking reimbursement for a compound dispensed on October 14, 2017. This compound included of the following ingredients:

- Mefenamic Acid
- Baclofen
- Flurbiprofen
- Meloxicam

The insurance carrier provided documentation to support that it paid the ingredients Flurbiprofen and Meloxicam in full. Therefore, these ingredients will not be considered in this dispute.

No evidence was provided that a reimbursement for the ingredients Mefenamic Acid and Baclofen was made. The DWC will review the insurance carrier's denial of payment for these ingredients.

1. Per submitted explanation of benefits dated December 8, 2017, Hartford Insurance Company of Midwest denied payment for the ingredients in question based on preauthorization. For compounds prescribed before July 1, 2018, preauthorization is only required for:

   - drugs identified with a status of "N" in the current edition of the ODG Appendix A[1];
   - any compound that contains a drug identified with a status of "N" in the current edition of the ODG Appendix A; and
   - any investigational or experimental drug.[2]

   The compound in question does not contain an ingredient identified with a status of "N" in the current edition of the ODG, Appendix A.

   The determination of a service's investigational or experimental nature is determined on a case by case basis through utilization review.[3] The insurance carrier provided no evidence that the it engaged in a prospective or retrospective utilization review to establish that the specific compound considered in this review is investigational or experimental.

   Because the insurance carrier failed to perform utilization review on the disputed compound, the requirement for preauthorization based on a premise that the compound is investigational or experimental is not triggered in this case. The insurance carrier's preauthorization denial for the ingredients in question is therefore not supported.

2. Because the insurance carrier failed to sufficiently support its denial of reimbursement, Memorial is entitled to reimbursement.

   The compound in question was billed by listing each drug included in the compound and calculating the charge for each drug separately.[4] The disputed ingredients are listed below with reimbursement amounts.[5] The calculation of the total allowable amount is as follows:

[1] *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary*
[2] 28 Texas Administrative Code §134.530(b)(1)
[3] Texas Insurance Code §19.2005(b)
[4] 28 Texas Administrative Code §134.502(d)(2)
[5] 28 Texas Administrative Code §134.503(c)

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Mefenamic Acid	38779066906	G	$123.60	1.8	$278.10	$222.48	$222.48
Baclofen	38779038809	G	$35.63	3	$133.61	$106.89	$106.89
						Total	$329.37

The total reimbursement is therefore $329.37. This amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $329.37.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services.
The DWC hereby ORDERS the respondent to remit to the requestor $329.37, 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	September 27, 2019 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.