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
Employers Preferred Insurance Co

MFDR Tracking Number
M4-18-3233-01

Carrier's Austin Representative
Box Number 04

MFDR Date Received
May 7, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the original bill as well and the reconsideration based on Fee Schedule."

Amount in Dispute: $798.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The compound medication for topical use remains denied based on medical necessity as per the official disability guidelines."

Response Submitted by: EIG Services, Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 28, 2017	Pharmacy Services - Compounds	$798.06	$798.06

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 §134.503 sets out the fee guidelines for pharmaceutical services.
3. 28 Texas Administrative Code §133.240 sets out requirements of utilization
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 6529 – Service were non-certified by UR. (See UR letter and examiner letter sent under separate cover)

Issues

1. Is the carrier's reason for denial of payment supported?
2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of $798.06 for a compound dispensed on May 28, 2017. The carrier denied the disputed compound with claim adjustment reason codes 6529 – "Service were non-certified by UR" and P12 – "Workers' compensation jurisdiction fee schedule adjustment."

   28 Texas Administrative Code §19.2009 (a) states in pertinent part,

   > Notice requirements of favorable or adverse determinations.
   >
   > (1) A URA must send written notification of a determination made in utilization review to the individuals specified in and within the timeframes required for utilization review

   Review of the submitted documentation found the UR (utilization review) was sent to the physician on February 9, 2017. No evidence of the requestor being notified of the utilization review decision was found.

   28 Texas Administrative Code §133.240 (q) states,

   > When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title (relating to Notice of Determinations Made in Utilization Review). Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title (relating to Requirements Prior to Issuing Adverse Determination), including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor, respectively.

   Insufficient evidence was found to support the health care provider was given a reasonable opportunity to discuss the health care. The carrier's denial is not supported.

2. The carrier indicated the services in dispute were adjusted based on the workers compensation fee schedule.

   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.

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)
Flurbiprofen	38779036209	$36.58	6	$274.35	$219.48	$219.48
Meloxicam	38779274601	$194.67	0.18	$43.80	$35.04	$35.04
Mefenamic Acid	38779066906	$123.60	1.8	$278.10	$222.48	$222.48
Baclofen	38779038809	$35.63	3	$133.61	$106.89	$106.89
Bupivacaine	38779052405	$45.60	1.2	$68.40	$54.72	$54.72
Ethoxy Diglycol	38779190301	$0.342	3	$1.28	$1.03	$1.03
Versapro Cream	38779252903	$3.20	44.82	$156.33	$143.42	$143.42
Compounding Fee	Na	$15.00	1	Na	$15.00	$15.00
					Total	$798.06

The total reimbursement is $798.06. The carrier did not make any payment therefore the fee schedule amount of $798.06 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 $798.06.

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 $798.06, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 12, 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.