TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION DISMISSAL

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
Twin City Fire Insurance Co

MFDR Tracking Number
M4-18-3393-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
May 15, 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: $566.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "On May 22, 2018, Memorial Compounding improperly requested medical fee dispute resolution (MFDR) for the denied medications. As summarized earlier, Memorial Compounding should have requested Medical Dispute by IRO if it were dissatisfied with the reconsideration outcome, as Division Rule 133.308 requires all retrospective medical necessity dispute go through Medical Dispute by IRO."

Response Submitted by: Burns Anderson Jury Brenner

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
November 14, 2017	Compound Medications	$566.53	$566.53

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted 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 Department of Insurance §133.240 sets out the requirements for medical payments and denials.
3. 28 Texas Department of Insurance §134.502 sets out the procedures for pharmaceutical benefits.
4. 28 Texas Department of Insurance §134.503 sets out the fee guidelines for pharmaceutical services.
5. The carrier denied the disputed services with the following explanation of benefit codes:
    - 197 – Payment denied/reduce for absence of precertification/authorization

Issues

1. Was the provider notified of adverse determination?
2. What rule is applicable to reimbursement?
3. Are the disputed services eligible for review by Medical Fee Dispute Resolution?

Findings

1. The requestor is seeking reimbursement of $566.53 for a compound dispensed on November 14, 2017. The carrier states in their position statement, "Twin City submitted an EOB denying payment based on Dr. Lombardo's utilization review."

   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

   Review of the submitted documentation found a letter dated December 6, 2017 informing the physician the requested health care did not meet established treatment standards. Also found was an explanation of bill review sent to the health care provider on January 23, 2018 with the reason code 197 – "Payment denied/reduce for absence of precertification/authorization."

   While the reviewed information supports the physician was notified of the adverse determination of medical necessity, insufficient evidence was found that the health care provider was given a reasonable opportunity to discuss the billed health care prior to the issuance of the adverse determination or that a medical necessity denial was issued at the time of claim review. Therefore, this information will not be included in this review.

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

3. 28 Texas Administrative Code §134.503 applies to the compound 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	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	$194.67	0.18	$43.80	$35.04	$35.04
Flurbiprofen	38779036209	$36.58	4.8	$219.48	$175.58	$175.58
Tramadol	38779237409	$36.30	6	$272.25	$217.80	$217.80
Cyclobenzaprine	38779039509	$46.332	1.8	$104.24	$83.39	$83.39
Bupivacaine	38779052405	$45.60	1.2	$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	Medical Fee Dispute Resolution Officer	July 19, 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.