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
LIBERTY MUTUAL FIRE INSURANCE

MFDR Tracking Number
M4-18-3470-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 18, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The above claimant received medication and the carrier still has not acknowledged receipt of service. The original bill was submitted to carrier on **11/15/2017 …** The carrier denied the reconsideration based on **lack of preauthorization or preauthorization was absent.**"

Amount in Dispute: $583.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The 11/14/17 compounded medication containing Flurbiprofen, Meloxicam, Mefenamic Acis, and Baclofen was denied due to the recommendation of a peer review. A copy of the peer reviewis attached."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 14, 2017	Pharmacy Services - Compounds	$583.89	$583.89

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 §133.240 sets out the general medical provisions for medical payments and denials.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
4. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
5. 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to

certified networks.

6. 28 Texas Administrative Code §19.2009 sets out the notice of determinations made in utilization review.
7. 28 Texas Administrative Code §19.2010 sets out the requirements prior to issuing adverse determination.
8. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - X435 – Based on peer review, further treatment is not recommended. For TX Jurisdiction claims only, Per TX Labor Code Sec 413.031 and 28 TAC Sections 133.308(H), (I), after reconsideration, you may seek review of a denial of medical necessity through a TDI-DWC Appointed Independent review organization. The form to initiate this process can be obtained from the DWC website at www.tdi.state.tx.us and must be sent via fax to 603-334-8064

Issues

1. Is Liberty Mutual Fire Insurance's reason for denial of payment supported?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the compound in question?

Findings

1. Memorial is seeking reimbursement for Flurbipren, Meloxicam, Mefenamic Acid and Baclofen dispensed on November 14, 2017.

   Liberty Mutual Fire Insurance denied the disputed drugs with claim adjustment reason code X435 – "– Based on peer review, further treatment is not recommended. For TX Jurisdiction claims only, Per TX Labor Code Sec 413.031 and 28 TAC Sections 133.308(H), (I), after reconsideration, you may seek review of a denial of medical necessity through a TDI-DWC Appointed Independent review organization. The form to initiate this process can be obtained from the DWC website at www.tdi.state.tx.us and must be sent via fax to 603-334-8064"

   28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding…medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding…medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021."

   28 Texas Administrative Code §133.240(q) states that the insurance carrier is required to comply with 28 Texas Administrative Codes §19.2009 and 19.2010 when denying payment based on an adverse determination.

   Review of the submitted documentation finds that Liberty Mutual submitted a document dated April 20, 2018, as support for a utilization review of the disputed compound. The division concludes that the submitted documentation does not support that Liberty Mutual Fire Insurance performed a utilization review as this document does not contain the elements of a utilization review required by 28 Texas Administrative Code §19.2009.

   Liberty Mutual Fire Insurance's denial reason is therefore not sufficiently supported. The disputed drug(s) will consequently be reviewed per applicable guidelines.

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; 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.

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Flurbiprofen	38779036209	G	$36.58	6	$274.35	$219.48	$219.48
Meloxicam	38779274601	G	$194.67	0.18	$43.80	$35.04	$35.04
Mefenamic	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	$583.89

The total reimbursement is therefore $583.89. This amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been discussed, it was considered.

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 $583.89, 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	8/31/2018 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.