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
City of Austin

MFDR Tracking Number
M4-18-3609-01

Carrier's Austin Representative
Box Number 43

MFDR Date Received
May 29, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The original bill was submitted to carrier on 07/17/2017 via certified mail … Memorial did not receive any correspondence as per rule so we submitted a Request for Reconsideration … The request was submitted and received by the carrier on 03/26/2017 via certified mail still with no response."

Amount in Dispute: $757.33

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was received at York on 03/26/2018, the bill was sent for a retrospective review for medical necessity to treat the compensable injury. The decision was non-certified according to the Official Disability Guidelines stating the request is not certified."

Response Submitted by: CareWorks

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 17, 2017	Duloxetine HCl DR 20 mg Capsules	$757.33	$757.33

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 §133.305 sets out the procedures for resolving medical disputes.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
4. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
5. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
6. 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to

certified networks.

7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment denied/reduced for absence of precertification/preauthorization.
   - P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, uses only if no other code is applicable.
   - Note: "PER RUR URA 5365 INVOICE 84447 NON CERTIFIED."

Issues

1. Is the insurance carrier's denial of payment based on lack of preauthorization supported?
2. Is the insurance carrier's denial of payment based on retrospective utilization review supported?
3. Is the Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drug in question?

Findings

1. Memorial is seeking reimbursement for Duloxetine HCl DR 20 mg capsules dispensed on June 17, 2017. City of Austin denied the disputed services with claim adjustment reason code 197 – "PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/ PREAUTHORIZATION."

   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 Duloxetine HCl DR 20 mg capsules are not identified with a status of "N" in the current edition of the ODG/*Appendix A.* City of Austin failed to articulate any arguments to support its denial for preauthorization. Therefore, the division concludes that the drug in question did not require preauthorization and City of Austin's denial of payment for this reason is not supported.

2. City of Austin also denied the disputed drug stating, "PER RUR URA 5365 INVOICE 84447 NON CERTIFIED." In its position statement, CareWorks argued on behalf of City of Austin that "the bill was sent for a retrospective review for medical necessity to treat the compensable injury. The decision was non-certified …"

   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 CareWorks submitted document dated April 24, 2018, as support for retrospective review of the disputed drug. The division concludes that the submitted documentation does not support that City of Austin performed a retrospective utilization review of the drug in question because this document does not indicate or support that the health care provider – in this case, Memorial Compounding Pharmacy – was notified of the findings, or that Memorial was afforded a reasonable opportunity to discuss the billed drug.

   The division concludes that City of Austin's denial for this reason is not sufficiently supported. The disputed drug will consequently be reviewed per applicable fee guidelines.

3. Because the insurance carrier failed to support its denial of payment, the drugs presented in this dispute are eligible for reimbursement as follows:

   28 TAC §134.503 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 division finds that the reimbursement for the disputed drugs is calculated as follows:

   - Duloxetine HCl DR 20 mg capsules: (6.99833 x 100 x 1.25) + $4.00 = $878.79

   The total allowable reimbursement amount is $878.79. Memorial is seeking $757.33. 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 $757.33.

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 $757.33, 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 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.