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 Rx

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-18-3747-01

Carrier's Austin Representative
Box 44

MFDR Date Received
June 4, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the reconsideration based on lack of preauthorization or preauthorization was absent. These medications do not require preauthorization therefore do not need a retrospective review."

Amount in Dispute: $361.41

RESPONDENT'S POSITION SUMMARY

The Austin carrier representative for Old Republic Insurance Co is White Espey PLLC. Flahive, Ogden & Latson acknowledged receipt of the copy of this medical fee dispute on June 13, 2018. 28 Texas Administrative Code §133.307 states, in relevant part:

> (d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
> (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

Review of the documentation finds that no response has been received on behalf of Old Republic Insurance Co from White Espey PLLC to date. The division concludes that Old Republic Insurance Co failed to respond within the timeframe required by §133.307(d)(1). For that reason the division will base its decision on the information available.

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
September 30, 2017	Compound Medication	$361.41	$35.04

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 reimbursement for compound medications
3. Explanation of Benefits:
   Issued October 25, 2017
   - P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.
   - HE75 – Prior authorization required

Findings

The Division makes the following conclusions based upon the information and documentation presented to the Division to date. Even though all the evidence was not discussed, it was considered.

1. Did the carrier reimburse Memorial for the disputed services?

Memorial Compounding Rx (Memorial) asserts that the carrier has not paid for the service in dispute. Review of the explanations of benefits provided finds that the carrier issued a payment in the amount of $326.37 to Memorial on October 25, 2017.

The Division concludes that Memorial has received payment for Flurbiprofen and Baclofen for the amounts listed on the DWC066.

2. Is additional reimbursement due?

The remaining item in dispute is Meloxicam 38779274601, for the amount of $35.04. The carrier denied the reimbursement as P13 – "Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies."

For the date of service in dispute the applicable rule is 28 Texas Administrative Code §134.530(b)(2) which 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 medication rendered on the date of service is not a drug identified with a status of "N" in the current edition of the ODG, *Appendix A*. Therefore, the division concludes that the based on the applicable workers' compensation jurisdictional regulation the carrier's denial is not supported.

The division payment policy is found in 28 Texas Administrative Code §134.503 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

The applicable reimbursement is calculated below.

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

The allowed amount for the service in dispute is $35.04. This amount is recommended.

Conclusion

The Division concludes an additional payment of $35.04 is due to the requestor.

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 $35.04, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order

Authorized Signature

		August 10, 2018
Signature	Medical Fee Dispute Resolution Officer	Date

RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 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 with the Division. **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.