



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

Hartford Insurance Company of Midwest

MFDR Tracking Number

M4-18-3871-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

June 8, 2018

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: \$555.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our investigation shows the following: The Overall Decision on the case is Non-Certified."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: October 11, 2017, Pharmacy Services - Compounds, \$555.68, \$555.68

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 §133.240 sets out adverse determination notification process.
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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
• 197 - "Precertification/authorization/notification absent"

Issues

1. Was the health care provider notified of adverse determination?
2. Is the carrier's reason for denial of payment supported?
3. Is the requestor entitled to reimbursement for the compound in question?

Findings

1. The respondent states in their position statement, "...The Overall Decision on the case in Non-Certified." Review of the submitted "Notice of Adverse Determination" dated February 1, 2017 could only find notification to the claimant and requesting physician. 28 Texas 133.240 (q) states in pertinent part,

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 an opportunity to discuss the health care prior to the non-certification of date of service January 3, 2017 which is not the date of service in dispute. This information will not be considered in this dispute for date of service October 11, 2017.

2. The requestor is seeking reimbursement of \$555.68 for a compound dispensed on October 11, 2017. The carrier denied the disputed compound with claim adjustment reason code 197 – "Precertification/authorization/notification absent."

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*. Therefore, 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 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 \text{ per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;
 - (B) Brand name drugs: $((AWP \text{ per unit}) \times (\text{number of units}) \times 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

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 & Type	Price/ Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Baclofen	38779038809	35.63	5.4	\$240.50	\$190.78	\$190.78
Amantadine	38779041105	24.23	3	\$90.84	\$72.69	\$72.69
Gabapentin	38779246109	59.85	3.6	\$269.33	\$204.66	\$204.66
Bupivacaine	38779052405	45.60	1.2	\$68.40	\$54.72	\$54.72
Amitriptyline	38779018904	18.24	1.8	\$41.04	\$32.83	\$32.83
					Total	\$555.68

The total reimbursement is \$555.68. 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 \$555.68.

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 \$555.68, 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 27, 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.