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**
Hartford Underwriters Insurance Co

**MFDR Tracking Number**
M4-18-4093-01

**Carrier's Austin Representative**
Box Number 47

**MFDR Date Received**
June 25, 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:** $798.06

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The Overall Decision on the case is Not Approved to Process."

**Response Submitted by:** The Hartford

## *SUMMARY OF FINDINGS*

| Date(s) of Service | Disputed Service(s) | Amount In Dispute | Amount Due |
|---|---|---|---|
| October 14, 2017 | Compound Medication | $798.06 | $798.06 |

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 remittance advice codes:
    - 197 – Precertification/authorization/notification absent

**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 $798.06 for a compound dispensed on October 14, 2017. The carrier states in their position statement, "…case not approved to process."

   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

   The available information was insufficient to support 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 (Explanation of benefits dated March 27, 2018 only lists 197 – Precertification/authorization/notification absent.) 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 does not require preauthorization. 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

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) |
|---|---|---|---|---|---|---|
| Flurbiprofen | 38779036209 | $36.58 | 6 | $274.35 | $219.48 | $219.48 |
| Meloxicam | 38779274601 | $194.67 | 0.18 | $43.80 | $35.04 | $35.04 |
| Mefenamic Acid | 38779066906 | $123.60 | 1.8 | $278.10 | $222.48 | $222.48 |
| Baclofen | 38779038809 | $35.63 | 3 | $133.61 | $106.89 | $106.89 |
| Bupivacaine | 38779052405 | $45.60 | 1.2 | $68.40 | $54.72 | $54.72 |
| Ethoxy Diglycol | 38779190301 | $0.342 | 3 | $1.28 | $1.03 | $1.03 |
| Versapro Cream | 38779252903 | $3.20 | 44.82 | $156.33 | $143.42 | $143.42 |
| Compounding Fee | NA | $15.00 | 1 | NA | $15.00 | $15.00 |
| | | | | | Total | $798.06 |

The total reimbursement is therefore $798.06. 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 $798.06.

***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 $798.06, 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<br>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**.