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 Casualty Insurance Co

MFDR Tracking Number
M4-18-4259-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
July 10, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The request for reconsideration in accordance with Rule 133.250 was submitted to the carrier but claim was processed and denied again. The insurance carrier is required to take final action on the claim that references the original denial. The claim was denied for not approved provider. The original claim was denied on 11/13/2017 code 71 based on not approved provider. Express Scripts check No: 3067850 states that code 70, based on Drug not on formulary is the new denial reason. There were not additional code changes or services rendered."

Amount in Dispute: $783.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Denial of the compounded medication in dispute was based on the following findings: Retro Review performed 12/4/17. Compound are considered off label as many ingredients are not FDA approved for topical use. TX required prescribers to submit request through UR and not the pharmacy. Sent UR needed letter to MD. Info request letter sent to prescribing MD. Denial issued to provider."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 25, 2017	Pharmacy Services - Compound	$783.06	$783.06

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 §134.240 sets out the requirements for medical payments and denials.

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 carrier denied with the following denial codes.
    - 197 – Precertification/authorization/notification absent

Issues

1. Did the provider support a utilization review was performed?
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 requestor is seeking reimbursement of $783.06 for a compound dispensed on October 25, 2017. The respondent states, "Retro Review performed 12/4/17." Review of the submitted documentation found a letter dated December 4, 2017, sent to Dr. Sparrow requesting information.

   This evidence does not support that a utilization review was performed for the services in dispute. Therefore, this information will not be considered in this dispute.

2. The carrier denied the services as 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*. The carrier failed to articulate any arguments to support its denial for preauthorization. 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 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
        (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.

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	$0.34	3	$1.28	$1.03	$1.03
Versapro Cream	38779252903	$3.20	44.82	$156.33	$143.42	$143.42
Compounding Fee	n/a	$15.00	1	n/a	Not in total on DWC060	Not in total on DWC060
					Total	$783.06

The total reimbursement is therefore $783.06. 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 $783.06.

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 $783.06, 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	September 11, 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.