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
Zurich American Insurance Company

MFDR Tracking Number
M4-18-4491-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 26, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "There is no PLN11 attached that was processed prior to services being rendered … If the carrier changes or adds to the denial it does not allow the health care provider to properly respond to the denial during the Medical Dispute process."

Amount in Dispute: $555.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor did not request and receive preauthorization for this investigational or experimental compound formulation, nor show it related to the compensable injury."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 28, 2017	Pharmaceutical Compound	$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 (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to certified networks.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - P6 – Based on entitlement to benefits.
    - 39 – Services denied at the time authorization/pre-certification was requested.

Issues

1. Did the insurance carrier raise a new defense in its response?
2. Is this dispute subject to dismissal based on compensability or relatedness?
3. Is the insurance carrier's denial based on preauthorization supported?
4. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the compound in question?

Findings

1. Memorial is seeking reimbursement for a compound dispensed on November 28, 2017. In its position statement, Flahive, Ogden & Latson, on behalf of the insurance carrier, argued that "… the Carrier issued its initial Adverse Determination for this prescription on January 17, 2018."

   The response from the insurance carrier is required to address only the denial reasons for the service in question presented to the requestor the request for medical fee dispute resolution (MFDR) was filed with the Texas Department of Insurance, Division of Workers' Compensation (DWC). Any new denial reasons or defenses raised shall not be considered in this review.[1]

   The submitted documentation does not support that a denial based on medical necessity was provided to Memorial before this request for MFDR was filed. Therefore, the DWC will not consider this argument in the current dispute review.

2. The insurance carrier denied the compound, in part, based on relatedness to the compensable injury. A dispute regarding the relatedness to the compensable injury must be resolved prior to a request for medical fee dispute.[2]

   The respondent is required to attach a copy of any related Plain Language Notice (PLN) if the medical fee dispute involves compensability or liability. Review of the submitted documentation finds that Flahive, Ogden & Latson failed to attach a copy of a related PLN on behalf of the insurance carrier to support a denial based on relatedness to the compensable injury.

   The dispute in question is not subject to dismissal as this denial reason was not sufficiently supported.

3. The insurance carrier denied the disputed compound based on preauthorization. Preauthorization is only required for:

    - drugs identified with a status of "N" in the current edition of the ODG Appendix A[3];
    - any compound that contains a drug identified with a status of "N" in the current edition of the ODG Appendix A; and
    - any investigational or experimental drug.[4]

   The compound in question does not contain an ingredient identified with a status of "N" in the current edition of the ODG, Appendix A.

   Flahive, Ogden & Latson, on behalf of the insurance carrier, argued that "The requestor did not request and receive preauthorization for this investigational or experimental compound formulation."

[1] 28 Texas Administrative Code §133.307(d)(2)(F)
[2] 28 Texas Administrative Codes §§133.305(b) and 133.307(c)(1)(B)(i)
[3] *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary*
[4] 28 Texas Administrative Code §134.540(b)

The determination of a service's investigational or experimental nature is determined on a case by case basis through utilization review.[5] Utilization review, includes a prospective, concurrent, or **retrospective review to determine the experimental or investigational nature** of health care services.[6]

Flahive, Ogden & Latson provided **no evidence** that the insurance carrier engaged in a prospective or retrospective utilization review to establish that the specific compound considered in this review is investigational or experimental.

Because the insurance carrier failed to perform utilization review on the disputed compound, the requirement for preauthorization based on a premise that the compound is investigational or experimental **is not triggered** in this case. The insurance carrier's preauthorization denial is therefore not supported.

4. Because the insurance carrier failed to sufficiently support its denial of reimbursement, Memorial is entitled to reimbursement.

   The compound in dispute was billed by listing each **drug** included in the compound and calculating the charge for each drug separately.[7] Each ingredient is listed below with its reimbursement amount.[8] The calculation of the total allowable amount is as follows:

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Baclofen	38779038809	G	$35.63	5.4	$240.50	$190.78	$190.78
Amantadine	38779041105	G	$24.23	3	$90.84	$72.69	$72.69
Gabapentin	38779246109	G	$59.85	3.6	$269.33	$204.66	$204.66
Bupivacaine	38779052405	G	$45.60	1.2	$68.40	$54.72	$54.72
Amitriptyline	38779018904	G	$18.24	1.8	$41.04	$32.83	$32.83
						Total	$555.68

   The total reimbursement is therefore $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 DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC 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	Laurie Garnes Medical Fee Dispute Resolution Officer	November 30, 2018 Date

[5] Texas Insurance Code §19.2005(b)
[6] Texas Insurance Code §4201.002(13)
[7] 28 Texas Administrative Code §134.502(d)(2)
[8] 28 Texas Administrative Code §134.503(c)

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 DWC 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.