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
Harford Accident & Indemnity Co

MFDR Tracking Number
M4-18-4751-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
August 6, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Bill for date of service 11/28/2017 was denied indicating lack of preauthorization or preauthorization was absent."

Amount in Dispute: $798.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our investigation shows the following: Review performed on the disputed medication. Determination was non-certified. Determination letter faxed to Dr. Nash."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 28, 2017	Flurbiprofen, Meloxicam, Mefenamic Acid, Baclofen, Bupivacaine HCL, Ethoxy Diglycol, Versapro Cream, Compounding Fee	$798.06	$798.06

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 §134.503 sets out the fee guidelines for pharmaceutical services.
3. 28 Texas Administrative Code §134.530 sets out prior authorization requirement for pharmacy services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 75 – No explanation
   - 85 – No explanation
   - P2 – Not a work related injury/illness and thus not the liability of the workers' compensation carrier

Issues

1. Is the insurance carrier's position supported?
2. Is the insurance 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, "Review performed on the disputed medication." Review of the Adverse Determination found CMPD: Baclofen, Gabapentin, Amantadine, Amitriptyline, Bupivacaine, Base and Flurbiprofen, Cyclobenzaprine, Bupivacaine, Meloxicam, Base and Tramadol, Flurbiprofen, Cyclobenzaprine, Bupivacaine, Meloxicam, Base." The disputed compound is for lurbiprofen, Meloxicam, Mefenamic Acid, Baclofen, Bupivacaine HCL, Ethoxy Diglycol, Versapro Cream, Compounding Fee. As the two compounds are not the same, the respondent's position is not supported."

2. The requestor is seeking reimbursement of $798.06 for a compound dispensed November 28, 2017. The carrier denied the disputed compound with several types of denials one being, "Not a work/related injury."

   28 TAC 134.240 (h) states,
   An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code §409.021, and §124.2 and §124.3 of this title (relating to Investigation of an Injury and Notice of Denial/Dispute) if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that:
   (1) the injury is not compensable;
   (2) the insurance carrier is not liable for the injury due to lack of insurance coverage; or
   (3) the condition for which the health care was provided was not related to the compensable injury.

   Review of the information available to the Division found insufficient evidence to support this requirement. The disputed service will be reviewed per applicable fee guideline.

3. 28 Texas Administrative Code §134.503 (c) 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

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Flurbiprofen	38779036209	G	$36.58	6	$274.35	$219.48	$219.48
Meloxicam	38779274601	G	$194.67	0.18	$43.80	$35.04	$35.04
Mefenamic Acid	38779066906	G	$126.60	1.8	$284.85	$222.48	$222.48
Baclofen	38779038809	G	$35.63	3	$133.61	$106.89	$106.89
Bupivacaine	38779052405	G	$45.60	1.2	$68.40	$54.72	$54.72
Ethoxy Diglycol	38779052405	G	$0.34	3	$1.28	$1.03	$1.03
Versapro Cream	38779252903	B	$3.20	44.82	$156.33	$143.42	$143.42
Fee	NA	NA	NA	NA	$15.00	$15.00	$15.00
						Total	$798.06

The total reimbursement is $798.06. This amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been discussed, it was considered.

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

		June 28, 2019
Signature	Medical Fee Dispute Resolution Officer	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.