



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 Accident and Indemnity Company

MFDR Tracking Number

M4-18-4767-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

August 6, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These medications do not require preauthorization therefore do not need a retrospective review."

Amount in Dispute: \$798.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Determination was non-certified."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 14, 2017	Compound Medication	\$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 (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 denied payment based on claim adjustment reason codes:
 - 75 – Prior authorization required
 - P2 – Not a work related injury/illness and thus not the liability of the workers’ compensation carrier.

Issues

1. Did the insurance carrier raise a new defense in its response?
2. Is this dispute subject to dismissal based on compensability?
3. Is the insurance carrier’s denial of payment 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 14, 2017. In its position statement, The Hartford argued that “Determination was non-certified.”

The response from the insurance carrier is required to address only the denial reasons 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 compensability 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 The Hartford 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 also 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 A³;
- 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.

The determination of a service’s investigational or experimental nature is determined on a case by case basis through utilization review.⁵ The Hartford 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.

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 §134.530(b)(1)

⁵ Texas Insurance Code §19.2005(b)

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.⁶ Each ingredient is listed below with its reimbursement amount.⁷ 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
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 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 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 \$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

Laurie Garnes
Medical Fee Dispute Resolution Officer

December 13, 2018
Date

⁶ 28 Texas Administrative Code §134.502(d)(2)

⁷ 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.