TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
Harford Underwriters

MFDR Tracking Number
M4-18-4771-01

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: "The current request for a compounded medication containing Flurbiprofen, Meloxicam, Mefenamic acid, Baclofen #10/5 days is not medically necessary or supported under current evidenced-based treatment recommendations."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 29, 2017	Pharmacy Services - Compounds	$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
   - 197 – Precertification/authorization/notification absent

Issues

1. Is the requestor'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 requestor states in their position statement, "These medications do not require preauthorization therefore do not need a retrospective review." 28 TAC §134.530 (g) states in pertinent part,

   > Retrospective review. Except as provided in subsection (f)(1) of this section, drugs that do not require preauthorization are subject to retrospective review for medical necessity in accordance with §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) and §133.240 of this title (relating to Medical Payments and Denials), and applicable provisions of Chapter 19 of this title.

   Based on the above, the requestor's position is not supported.

2. The requestor is seeking reimbursement of $798.06 for a compound containing Flurbiprofen, Meloxicam, Mefenamic Acid, Baclofen, Bupivacaine, Ethoxy Diglycol, and Versapro Cream dispensed November 29, 2017. The first denial from Express Scripts was dated December 13, 2017 with rejection code "75".

   The insurance carrier performed a utilization review on December 18, 2017. However, this adverse determination is for CMPD: Flurbiprofen, Meloxicam, Mefenamic acid and Baclofen. Not the same as the compound in dispute for date of service November 29, 2017. Therefore, the Division cannot consider the respondent's position for not authorizing the service as indicated on April 27, 2018 explanation of benefits.

3. 28 Texas Administrative Code §134.503 (c) applies to the compounds 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;

   Based on amounts submitted on DWC066.

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.

The based on the fee schedule, a reimbursement of $798.06 is due.

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

		July 9, 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.