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
American Zurich Insurance Co

MFDR Tracking Number
M4-18-5121-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 22, 2018

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $798.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the Carrier does not know what amount Memorial would be entitled to, assuming it can show it entitled to payment and fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 10, 2017	Compound pharmacy	$543.46	$543.46

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 reimbursement guidelines for professional medical services.
3. The insurance carrier denied payment for the disputed services with the following claim adjustment codes:

- 15 – The authorization number is missing, invalid or does not apply to the billed services or provider
- 216 – Based on the finds of a review organization

Issues

1. Is the insurance carrier's reasons for denial of payment supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of pharmacy services rendered on December 10, 2017. The insurance carrier denied based on lack of prior authorization and the findings of a review organization.

   Review of the submitted documentation found insufficient evidence to support an adverse determination by a review organization. This denial will not be considered in this review.

   28 TAC §134.530 (b) (1) (A)(B)(D) states 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, and any updates, any prescription drug created through compounding prescribed before July 1, 2018 that contains a drug identified with a status of "N" in the Appendix mentioned above, 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).

   Review of the submitted DWC066 found none of the listed medication have an "N" status and insufficient evidence of a review from a utilization review organization that found the services investigational or experimental.

   The insurance carrier's denial is not supported. The disputed services will be reviewed per applicable fee guideline.

2. 28 TAC §134.503 (c) states the reimbursement for prescription drugs the is the lesser of 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 of the providers submitted charge.

   - Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
   - Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;
   - 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;

   Calculation based on the above is as follows:

Medication	NDC	Units	AWP	MAR	Billed amount
Flurbiprofen	38779036209	6	$36.58	$36.58 x 1.25 x 6 = $274.35	$210.90
Meloxicam	38779274601	0.18	$194.67	$194.67 x 1.25 x 0.18 = $43.80	$35.04
Mefenamic Acid	38779066906	1.8	$123.60	$123.60 x 1.25 x 1.8 = $278.10	$146.90
Baclofen	38779038809	3	$35.63	$35.63 x 1.25 x 3 = $133.61	$102.60
Bupivacaine	38779052405	1.2	$45.60	$45.60 x 1.25 x 1.2 = $68.40	$48.02
				Total	$543.46

3. The lesser or allowed amount is the billed amount of $543.46. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established payment is due. As a result, the amount ordered is $543.46.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is/is not entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $543.46, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

		December 20, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.