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 Casualty Insurance Co

MFDR Tracking Number
M4-19-0519-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
October 1, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the reconsideration based not approved provider. Memorial Compounding is an approved provider and should be reimbursed accordingly."

Amount in Dispute: $798.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The guidelines do not recommend compounded topical analgesics as they are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least one drug (or drug class) that is not recommended in not recommended."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 14, 2018	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 §134.502 sets out the procedures for pharmaceutical benefits.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
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Issues

1. Is the insurance carrier's position supported?
2. Is the requestor entitled to reimbursement for the compound in question?

Findings

1. The requestor is seeking reimbursement of $798.06 for a compound dispensed March 14, 2018. The respondent states in their position statement, "The guidelines do not recommend compounded topical analgesics as they are largely experimental…"

   The determination of a service's investigational or experimental nature is determined on a case by case basis as a utilization review pursuant to Texas Insurance Code §4201.002. Further, Texas Insurance Code §4201.002(13) states that utilization review, in relevant part, "includes a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services."

   DWC found no evidence that the insurance carrier engaged in a prospective or retrospective utilization review (UR) as required by Texas Insurance Code §4201.002 in order to establish that the following compound is investigational or experimental in nature.

   Because the respondent failed to perform UR on the services in dispute, the requirement for preauthorization under TAC §134.530(b)(1)(C) is not triggered in this case. The carrier's preauthorization denial is therefore not supported.

   Absent any evidence that the carrier presented other defenses to requestor before medical fee dispute resolution that conform with the requirements of Title 28, Part 2, Chapter 133, Subchapter C, DWC finds that the compounds in question are eligible for reimbursement.

2. 28 TAC §134.503 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;

   The reimbursement is calculated as follows:

Ingredient	NDC	Price/ Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Flurbiprofen	38779036209	$36.58	6	$274.35	$219.48	$219.48
Meloxicam	38779274601	$194.68	0.18	$43.80	$35.04	$35.04
Mefenamic Acid	38779066906	$123.60	1.8	$278.10	$222.48	$222.48
Baclofen	38779038809	$35.63	3	$133.61	$106.89	$106.89
Bupivacaine	38779052405	$45.60	1.2	$68.40	$54.72	$54.72
Ethoxy Diglycol	38779190301	$45.60	1.2	$68.40	$54.72	$54.72
Versapro Cream	38779252903	$3.20	44.82	$156.33	$143.42	$143.42
Compounding Fee	NA	$15.00	1	NA	$15.00	$15.00
					Total	$798.06

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

Conclusion

For the reasons stated above, DWC 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. DWC hereby ORDERS the respondent to remit to the requestor 798.06, plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this order.

Authorized Signature

		October 31, 2018
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.