



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

New Hampshire Insurance Co

MFDR Tracking Number

M4-19-0114-01

Carrier's Austin Representative

Box 19

MFDR Date Received

September 7, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Texas Labor Code Section 408.027 (b) requires that the carrier must pay, reduce, deny or determine to audit the health provider's claim no later than the 45th day after the date of the receipt by the carrier. Memorial did not receive any correspondence as per rule... As of today, we still haven't received any correspondences."

Amount in Dispute: \$645.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Extent of Injury/Relatedness Dispute is unresolved.":

Response submitted by: Flahive, Ogden, Latson

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: March 26, 2018, Compounded Pharmacy Service, \$645.94, \$591.32

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. 28 Texas Administrative Code §134.540 sets out the closed formulary requirements for claims subject to certified networks.
5. Texas Insurance Code, Chapter 4201 provides requirements related to utilization review.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 197 - Payment denied/reduced for absence of precertification/authorization
  - 193 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

### Issues

1. Did the respondent raise a new issue?
2. Is the insurance carrier's reason for denial of payment supported?
3. Is the health care provider entitled to reimbursement of the disputed services?

### Findings

1. The respondent states, "The extent of injury/relatedness dispute is unresolved." 28 TAC § 133.307 (d) (2) (F) states in pertinent part, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." Review of the submitted documentation found no denials based on extent or relatedness. The respondent's position will not be considered in this review.
2. The requestor is seeking reimbursement of pharmacy services rendered on March 26, 2018. The insurance carrier denied the disputed service based on lack of pre-authorization.

28 Texas Administrative Code §134.540(b) states that preauthorization is only required for:

- (1) drugs identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary*, and any updates;
- (2) any compound that contains a drug identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary*, and any updates; and
- (3) 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 disputed services found the requestor was not required to seek preauthorization pursuant to §134.540(b)(2) because none of the compounded ingredients have a status of "N" in the current edition of the ODG/Appendix A.

Flahive, Ogden & Latson, states in their position statement, "The Requestor did not request and receive preauthorization for this investigational or experimental compound formulation."

Texas Insurance Code §4201.002(13) states, in relevant part, that utilization review "includes a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services."

The division found no evidence of a prospective or retrospective utilization review (UR) specific to this disputed date of service as required by Texas Insurance Code §4201.002 to establish that the disputed compound is investigational or experimental in nature. The requirement for preauthorization under §134.540(b)(2) is not triggered in this case and the preauthorization denial is not supported.

3. 28 Texas Administrative Code §134.503 applies to the services 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:  $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.25) + \$4.00$  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 compounds in dispute were billed by listing each drug included in the compound and calculating the charge for each drug separately as required by 28 Texas Administrative Code §134.502(d)(2). Reimbursement is calculated as follows:

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Cyclobenzaprine	65162054150	G	\$1.09	30	\$35.64	\$90.26	\$35.64
Baclofen	38779038809	G	\$35.63	5.4	\$240.50	\$190.78	\$190.78
Amantadine	38779041105	G	\$24.23	3	\$90.84	\$72.69	\$72.69
Gabapentin	38779246109	G	\$59.85	3.6	\$269.33	\$204.66	\$204.66
Bupivacaine	38779052405	G	\$45.60	1.2	\$68.40	\$54.72	\$54.72
Amitriptyline	38779018904	G	\$18.24	1.8	\$41.04	\$32.83	\$32.83
						<b>Total</b>	<b>\$591.32</b>

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 \$591.32

**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 \$591.32, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

May 21, 2019

**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.