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
State Office of Risk Management

MFDR Tracking Number
M4-19-0242-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
September 17, 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 receipt by the carrier. Memorial did not receive any correspondence as per rule..."

Amount in Dispute: $583.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office respectively requests the Division to dismiss this request for dispute resolution as the provider has failed to submit a complete request for reconsideration in accordance with Rule §133.250."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 14, 2018	Compounded pharmacy	$583.89	$583.89

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 details the pharmacy fee guideline.
3. 28 Texas Administrative Code §134.530 sets out the requirements for prior authorization
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 197 – Payment denied/reduced for absence of precertification/authorization

Issues

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

Findings

The respondent states in their response, "…the provider has failed to submit a complete request for reconsideration…" Review of the submitted documentation from the requestor found a request for reconsideration dated May 1, 2018. Evidence of receipt by the insurance carrier was dated May 21, 2018. Based on the above, the respondent's position will not be considered in this review.

1. The requestor is seeking reimbursement of a compound pharmacy medication provided on March 14, 2018. The insurance carrier denied disputed services based on lack of preauthorization. 28 TAC §133.307 (d)(2)(F) allows MFDR to 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. The applicable DWC rule is found below regarding prior authorization is found below.

   28 TAC §134.530 (b)(1)(A)(B)(D) states in relevant parts, 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 Appendix A, or 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 medication listed on the DWC066 found none are listed as "N" drugs and insufficient evidence was found to support an adverse determination by an independent review organization that found the services were investigational and experimental.

   Based on the above, the insurance carrier's denial is not supported. The services in dispute will be reviewed per applicable fee guidelines.

2. 28 TAC §134.503 (c) states the reimbursement for prescription drugs 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 or the health care providers submitted amount.
    - 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

   The calculation of the fee based on the above is as follows:

Medication	NDC	AWP	Units	MAR	Billed amount
Flurbiprofen	38779036209	$36.58	6	$274.35	$219.48
Meloxicam	38779274601	$194.67	0.18	$43.80	$35.04
Mefenamic Acid	38779066906	$123.60	1.8	$278.10	$222.48
Baclofen	38779038809	$35.63	3	$133.61	106.89
				Total	$583.89

3. The allowable (lesser amount) is the health care providers submitted charge of $583.89. 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 $583.89.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), DWC has determined the requestor is entitled to additional reimbursement for the disputed services.
DWC hereby ORDERS the respondent to remit to the requestor $583.89, plus applicable accrued interest per 28 TAC §134.130 due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 20, 2019 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.