



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

XL Insurance America Inc

MFDR Tracking Number

M4-19-0350-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

September 21, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the reconsideration based on partial payment. The above claimant received medication as prescribed by referral provider.

Amount in Dispute: \$515.21

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor did not request and receive preauthorization for this investigational or experimental compound formulation, or for this compound that is not included in the Division's Closed Formulary.

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 26, 2018	Gabapentin, Amitriptyline, Amantadine, Flurbiprofen	\$515.21	\$515.21

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
- 28 Texas Administrative Code §134.530 sets out prior authorization requirement for pharmacy services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
 - 197 – Precertification/authorization/notification absent
 - 18 – Exact duplicate claim/service

Issues

1. Is the insurance carrier’s reason for denial of payment supported?
2. Is the requestor entitled to reimbursement for the compound in question?

Findings

1. The requestor is seeking reimbursement of \$515.21 for a compound dispensed March 26, 2018. The carrier denied the disputed compound with claim adjustment reason based on lack of preauthorization.

28 Texas Administrative Code §134.530(b)(1)(A) which states that preauthorization is **only** required for:

1) Preauthorization is only required for:

(A) 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;

(B) any prescription drug created through compounding prescribed before July 1, 2018 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;

(C) any prescription drug created through compounding prescribed and dispensed on or after July 1, 2018; and

(D) 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).

The division finds that the compound rendered on the date of service in question does not include a drug identified with a status of “N” in the current edition of the ODG, *Appendix A*.

The carrier’s denial of payment for is not supported. The disputed compound will be reviewed for reimbursement.

2. 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; or

The fee calculation is as follows:

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Amantadine	38779041105	G	\$24.23	4.8	\$145.35	\$116.30	\$116.30
Gabapentin	38779246109	G	\$59.85	3	\$224.44	\$179.55	\$179.55
Flurbiprofen	38779036209	G	\$36.58	4.8	\$219.48	\$175.58	\$175.58
Amitriptyline	38779018904	G	\$18.24	2.4	\$54.72	\$43.78	\$43.78
						Total	\$515.21

The total reimbursement is \$515.21. 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.

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 \$515.21.

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 \$515.21, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		August 19, 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.