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
Electric Insurance Co

MFDR Tracking Number
M4-19-0411-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
September 21, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the reconsideration based on lack of preauthorization. These medications do not require preauthorization therefore do not need a retrospective review."

Amount in Dispute: $600.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The medications in dispute in this matter was denied based on retrospective medical necessity. The peer review report is attached. The physician did review the medications prescribed and found the medications were not medically necessary."

Response Submitted by: Downs Stanford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 27, 2018	Cyclobenzaprine, Gabapentin, Lenzapatch	$600.54	$272.48

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 fee guidelines for pharmaceutical services.
3. 28 Texas Administrative Code §134.530 sets out prior authorization requirement for pharmacy services.
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
   - 18 – Exact duplicate claim/service
   - 5264 – Payment is denied-service not authorized

Issues

1. Did the insurance carrier raise a new issue?
2. Is the insurance carrier's reason for denial of payment supported?
3. Is the requestor entitled to reimbursement for the compound in question?

Findings

1. The respondent states in their position, "The medications in dispute in this matter was denied based on retrospective medical necessity. The peer review report is attached. The physician did review the medications prescribed and found the medications were not medically necessary." 28 TAC 133.307 (d) (2) (F) states,

   > 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. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section.

   Review of the submitted explanation of benefits found only a denial for lack of preauthorization. The peer review that determined the services were not medically necessary did not result in a medical necessity denial presented to the requestor prior to the date of the MFDR request. The request for medical fee dispute resolution will proceed.

2. The requestor is seeking reimbursement of $600.54 for Cyclobenzaprine 10mg, Gabapentin 300 mg, and Lenzapatch, dispensed on March 27, 2018. The insurance carrier denied the services based on lack of preauthorization.

   28 Texas Administrative Code §134.530(b)(1)(A) states in pertinent part, that 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, *ODG Workers' Compensation Drug Formulary,* and any updates;

   Review of Appendix A found Cyclobenzaprine 10 mg and Gabapentin 300 mg are not identified as "N" drugs. The insurance carrier's denial for lack of preauthorization for these medications is not supported. The applicable fee calculation is shown below.

   Review of Appendix A found Lidocaine a component of the Lenzapatch 4% is listed as a "N" drug. The insurance carrier's denial for this medication is supported. No additional payment is recommended.

3. 28 Texas Administrative Code §134.503 (c) applies to the medication 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;

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Cyclobenzaprine	65162054150	G	$1.09	90	$122.85	$155.78	$122.85
Gabapentin	67877022305	G	$1.33	90	$149.63	$177.26	$149.63
						Total	$272.48

The total reimbursement is $272.48. 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 $272.48.

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 $272.48, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		June 21, 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.