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 Underwriters Insurance Company

MFDR Tracking Number
M4-19-0582-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
October 3, 2018

Response Submitted by:
The Hartford

REQUESTOR'S POSITION SUMMARY

"The carrier denied the reconsideration based on **drug not on formulary**. These medications do not require preauthorization therefore do not need a retrospective review."

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Compounds are considered off label as many ingredients are not FDA approved for topical use."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 30, 2018	Compound Medication	$726.62	$726.62

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

The service in dispute is a compounded medication. Applicable 28 Texas Administrative Code §134.530 states that preauthorization is only required for 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.

Issues

1. Is the insurance carrier's denial of payment based on preauthorization supported?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the compound in question?

Findings

1. Per explanation of benefits dated February 27, 2018, the insurance carrier denied the compound in question for lack of authorization prior to dispense.

The disputed compound did not contain an "N" drug. The insurance carrier presented evidence that it performed the utilization review in accordance with Insurance Code, Chapter 4201 and Chapter 19, Subchapter U of the Texas Administrative Code. This utilization review was dated March 15, 2018.

The insurance carrier presented no evidence that it performed utilization review **prior to or concurrent with the processing of the medical bill** in dispute as required by 28 Texas Administrative Code §133.240. The DWC concludes that the insurance carrier's denial of payment for this compound is not supported.

2. Because the insurance carrier failed to sufficiently support its denial of reimbursement, Memorial is entitled to reimbursement.

   The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately.[1] Each ingredient is listed below with its reimbursement amount.[2] The calculation of the total allowable amount is as follows:

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Meloxicam	38779274601	G	$194.67	0.18	$43.80	$35.04	$35.04
Flurbiprofen	38779036209	G	$36.58	4.8	$219.48	$175.58	$175.58
Tramadol	38779237409	G	$36.30	6	$272.25	$217.80	$217.80
Cyclobenzaprine	38779039509	G	$46.33	1.8	$104.24	$83.39	$83.39
Bupivacaine	38779052405	G	$45.60	1.2	$68.40	$54.72	$54.72
Ethoxy Diglycol	38779190301	G	$0.34	3	$1.28	$1.03	$1.03
Versapro Cream	38779252903	B	$3.20	45.02	$157.03	$144.06	$144.06
Fee	NA	NA	NA	NA	$15.00	$15.00	$15.00
						Total	$726.62

The total reimbursement is therefore $726.62. This amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $726.62.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services.
The DWC hereby ORDERS the respondent to remit to the requestor $726.62, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	August 29, 2019 Date

[1] 28 Texas Administrative Code §134.502(d)(2)
[2] 28 Texas Administrative Code §134.503(c)

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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the 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 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.