



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

Trumbull Insurance Co

MFDR Tracking Number

M4-19-0680-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

October 9, 2018

REQUESTOR'S POSITION SUMMARY

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."

Amount in Dispute: \$702.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Compounds are considered off label as many ingredients are not FDA approved for topical use. TX requires prescribers to submit request through UR and not the pharmacy."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: January 30, 2018, Pharmacy Services - Compounds, \$702.68, \$702.68

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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
• 70

Issues

1. Did the respondent raise a new issue?
2. Is the requestor entitled to reimbursement for the compound in question?

Findings

1. The requestor is seeking reimbursement of \$702.68 for a compound dispensed on January 30, 2018. The respondent states, "Compounds are considered off label as many ingredients are not FDA approved for topical use. TX requires prescribers to submit requests through UR and not the pharmacy."

DWC found no evidence that the insurance carrier engaged in a prospective or retrospective utilization review (UR) as required by Texas Insurance Code §4201.002 in order to support their position of "off label."

Because the insurance carrier failed to perform UR on the services in dispute, the requirement for preauthorization under §134.530(b)(1)(C) is not triggered in this case. The carrier's position is not supported.

Absent any evidence that the carrier presented other defenses to requestor before medical fee dispute resolution that conform with the requirements of Title 28, Part 2, Chapter 133, Subchapter C, DWC finds that the compounds in question are eligible for reimbursement.

2. 28 Texas Administrative Code §134.503 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: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;
 - (B) Brand name drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 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

| Ingredient | NDC | Price/ Unit | Total Units | AWP Formula §134.503(c)(1) | Billed Amt §134.503 (c)(2) | Lesser of (c)(1) and (c)(2) |
|--------------------|-------------|----------------|----------------|-------------------------------|----------------------------------|-----------------------------------|
| Baclofen | 38779038809 | \$35.63 | 5.4 | \$240.50 | \$190.78 | \$190.78 |
| Amantadine | 38779041105 | \$24.23 | 3 | \$90.84 | \$72.69 | \$72.69 |
| Gabapentin | 38779246109 | \$59.85 | 3.6 | \$269.33 | \$204.66 | \$204.66 |
| Bupivacaine | 38779052405 | \$45.60 | 1.2 | \$68.40 | \$54.72 | \$54.72 |
| Amitriptyline | 38779018904 | \$18.24 | 1.8 | \$41.04 | \$32.83 | \$32.83 |
| Ethoxy Diglycol | 38779190301 | \$0.34 | 4.2 | \$1.80 | \$1.44 | \$1.44 |
| Versapro Cream | 38779252903 | \$3.20 | 40.8 | \$142.31 | \$130.56 | \$130.56 |
| Compounding Fee | NA | \$15.00 | 1 | N/A | \$15.00 | \$15.00 |
| | | | | | \$702.68 | \$702.68 |

The total reimbursement is \$702.68. 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 \$702.68.

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. DWC hereby ORDERS the respondent to remit to the requestor 702.68, 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

November 9 , 2018
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.