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
Amerisure Insurance Co

MFDR Tracking Number
M4-19-0797-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
October 12, 2018

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $726.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the Carriers position is that the medications requested were denied and not owed with the final adjudication on extent of injury."

Response Submitted by: Amerisure

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 27, 2018	Pharmacy Services - Compounds	$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

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:
   - 197 – Payment denied/reduced for absence of precertification/preauthorization

Issues

1. Did the insurance carrier raise a new issue?
2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of $726.62 for a compound dispensed on February 27, 2018. The carrier denied the disputed compound with claim adjustment reason code 197 – "Payment denied/reduced for absence of precertification/preauthorization."

   The requestor states in their position statement, "…medications requested were denied and not owed with the final adjudication on extent of injury."

   28 Texas Administrative Code §133.307(d)(2)(F) states, in relevant part, "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."

   Review of the submitted documentation finds insufficient evidence to support the insurance carrier presented a "extent of injury" denial to health care provider in accordance with 28 Texas Administrative Code §133.240 prior to the date the request for medical fee dispute resolution (MFDR) was filed.

   DWC concludes that this defense presented in respondent's position statement shall not be considered for review because this assertion constitutes a new defense pursuant to 28 Texas Administrative Code §133.307(d)(2)(F).

2. 28 TAC §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: ((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

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)
Meloxicam	38779274601	$194.67	0.18	$43.80	$35.04	$35.04
Flurbiprofen	38779036209	$36.58	4.8	$219.48	$175.58	$175.58
Tramadol	38779237409	$36.30	6	$272.25	$217.80	$217.80
Cyclobenzaprine	38779039509	$46.33	1.8	$104.24	$83.39	$83.39
Bupivacaine	38779052405	$45.60	1.2	$68.40	$54.72	$54.72
Ethoxy Diglycol	38779190301	$0.34	3	$1.28	$1.03	$1.03
Versapro Cream	38779252903	$3.20	45.02	$157.03	$144.06	$144.06
Compounding Fee	N/A	$15.00	1	N/A	$15.00	$15.00
					Total	$726.62

The total reimbursement is $726.62. 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 $726.62.

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 $726.62, plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this order.

Authorized Signature

		November 9, 2018
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.