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

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
TASB Risk Mgmt Fund

MFDR Tracking Number
M4-19-1125-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
October 29, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the reconsideration based on lack of preauthorization or preauthorization was absent."

Amount in Dispute: $555.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "A peer review conducted on 02/14/18 indicated… the current medications would no longer be utilized for the work injury."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
February 8, 2018	Baclofen, Amantadine, Gabapentin, Bupivacaine, Amitriptyline	$555.68	$555.68

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted 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 §134.530 sets out the requirements of preauthorization for pharmacy services.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmacy services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 216 – Based on findings of a review organization
   - 197 – Payment adjusted for absence of precertification/authorization
   - 55 – Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.

Issues

1. Is the insurance carrier's denial supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for a compound medication for date of service February 8, 2018 in the amount of $555.68. The insurance carrier denied the disputed service based on the findings of a review organization.

   Review of the submitted documentation found a review was done for medical necessity of disputed services however, this review was done on February 14, 2018 after the disputed date of service. This denial will not be considered in this review. The other denial for preauthorization and investigation and experimental is found below.

2. 28 TAC 134.530 (b) (1) (A) (B) (D) states 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, any prescription drug created through compounding prescribed before July 1, 2018 that contains a drug identified with a status of "N" or 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).

   Review of Appendix A referenced above found none of the disputed medications are identified as a "N" drug or was evidence of a utilization review that found the disputed medications were considered experimental and investigational. The insurance carrier's denial is not supported. The disputed service will be reviewed per applicable fee guideline.

3. 28 TAC 134.503 (c) states the insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of 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.

   - Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
   - Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;

   The calculation of the allowable based on the above is found below.

Medication	NDC	Units	AWP	MAR	Billed amount
Baclofen	38779038809	5.4	$35.63	$35.63 x 5.4 x 1.25 = $240.50	$190.78
Amantadine	38779041105	3.0	$24.23	$24.23 x 3 x 1.25 = $90.86	$72.69
Gabapentin	38779246109	3.6	$59.85	$59.86 x 3.6 x 1.25 = $269.37	$204.66
Bupivacaine	38779052405	1.2	$45.60	$45.60 x 1.2 x 1.25 = $68.40	$54.72
Amitriptyline	38779018904	1.8	$18.24	$18.24 x 1.8 x 1.25 = $41.04	$32.83
				Total $710.17	$555.68

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established payment is due. As a result, the amount ordered is $555.68.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $555.68, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

		December 31, 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.