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**
American Zurich Insurance Co

**MFDR Tracking Number**
M4-19-1133-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
October 29, 2018

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "These medications do not require preauthorization therefore do not need a retrospective review."

**Amount in Dispute:** $555.68

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The Extent of Injury Dispute has been resolved in Carrier's favor. Any Relatedness Dispute is unresolved."

**Response Submitted by:** Flahive, Ogden & Latson

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| February 16, 2018 | Baclofen, Amantadine, Gabapentin, Bupivacaine, Amitriptyline | $555.68 | $204.66 |

## *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 §134.530 sets out the reimbursement guidelines 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:
   - HE75 – Prior authorization required to process this bill

**Issues**

1. Is the respondent's position supported?
2. Is the insurance carrier's reason for denial or reduction of payment supported?
3. What rule is applicable to reimbursement?
4. Is the requestor entitled to additional reimbursement?

**Findings**

1. The respondent states, "The extent of injury dispute has been resolved in Carrier's favor. Any relatedness dispute is unresolved."

   28 TAC 133.307 (d)(2)(F) states MFDR's 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 documents found no denial of the disputed services based on extent of injury or relatedness.

   Based on the above, the respondent's position will not be considered in this review. The disputed services will be reviewed per applicable DWC rules and fee guidelines.

2. The requestor is seeking reimbursement for a compound medication for date of service February 16, 2018 in the amount of $555.68. The insurance carrier denied the disputed service based on lack of preauthorization.

   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 |

4. The lesser amount is the billed amount of $555.68. The insurance carrier paid $351.02 on March 5, 2018. The remaining balance of $204.66 is due to the requestor.

**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 $204.66.

## *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 $204.66, plus applicable accrued interest per 28 TAC §134.130 due within 30 days of receipt of this order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | December 31, 2019<br>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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to 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 TAC §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.