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 ACCIDENT & INDEMNITY COMPANY

MFDR Tracking Number
M4-19-1169-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
November 1, 2018

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $798.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ODG does not support the use of compounded products."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 23, 2018	Pharmaceutical Compound	$798.06	$798.06

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 §134.503 sets out the fee guideline for pharmacy services.
3. Texas Labor Code §413.031 sets out provisions regarding medical dispute resolution.
4. 28 Texas Administrative Code §134.530 sets out closed formulary requirements for non-network claims.
5. 28 Texas Administrative Code Chapter 19, Subchapter U sets out rules for utilization review of health care.
6. 28 Texas Administrative Code §19.2005 sets out general standards of utilization review.
7. Texas Insurance Code §4201.002 defines words and terms related to utilization review.
8. Texas Labor Code §408.021 entitles an injured employee to all required health care as and when needed.
9. The insurance carrier denied payment based on the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - P2 -Not a work related injury/illness and thus not the liability of the workers' compensation carrier.
   - 197 – Precertification/authorization/notification absent

Issues

1. Are there unresolved issues regarding liability for the injury?
2. Was preauthorization required?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment code P2 –"Not a work related injury/illness and thus not the liability of the workers' compensation carrier."

   The insurance carrier did not maintain this denial reason upon appeal or in the respondent's position statement.

   Furthermore, the respondent did not submit copies of any PLN-11 or plain language notices issued in accordance with Rule §124.2, as required by Rule $133.307(d)(2)(H).

   Rule §124.2(h) requires notification to the division and claimant of any dispute of disability or extent of injury using plain language notices with language and content prescribed by the division. Such notices "shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim."

   Rule §133.307(d)(2)(H) further requires that If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with Rule §124.2 (relating to carrier reporting and notification requirements).

   Because the respondent failed to meet the requirements of Rule §133.307(d)(2)(H) regarding notice of issues of liability, the respondent has waived the right to raise such issues during dispute resolution.

   Consequently, the division concludes there are no outstanding issues of compensability or liability for the injury.

2. The insurance carrier denied disputed services with claim adjustment code 197 – "Precertification/ authorization/ notification absent."

   Rule §134.500(3) defines the division's closed formulary to include all available FDA approved drugs prescribed for outpatient use, with certain exclusions. Rule §134.530(b)(1) requires preauthorization only for:

   - drugs identified with status N in the current edition of ODG Appendix A[1];
   - compounds containing a drug identified with status N in the current edition of ODG Appendix A; and
   - any investigational or experimental drug.

   The disputed compound contains only FDA approved drugs not identified with status N in ODG Appendix A.

   Whether a service is investigational or experimental must be determined on a case-by-case basis by utilization review — considering any special circumstances that require deviation from screening criteria or guidelines.[2] Utilization review includes a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of the health care.[3]

   Labor Code §408.021(a) entitles an injured employee to all health care required by the nature of the injury as and when needed, including health care that cures or relieves the effects of the injury; promotes recovery; or enhances the ability to return to or retain employment. In the adoption preamble to 28 Texas Administrative Code Chapter 19, Subchapter U, the division emphasized "an injured employee under both network and non-network coverage is entitled to all medically necessary health care services, including experimental and investigational health care services." [4] And while investigational or experimental services require preauthorization, no service may be deemed investigational or experimental absent review by a licensed UR agent.

[1] *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary*
[2] 28 Texas Administrative Code §19.2005(b)
[3] Texas Insurance Code §4201.002(13)
[4] ADOPTED RULES February 15, 2013, 38 *Texas Register* 895

The adoption preamble to Subchapter U expressly states:

> Even though the determination that a health care service is experimental or investigational does not in itself constitute an adverse determination, only a URA should make determinations that health care services are experimental or investigational, based on the definition of "utilization review." [4]

Review of the submitted information finds a copy of an adverse determination dated October 3, 2016. This determination was made two years prior to the date of service and is not related to the services in dispute. Nor does the respondent support or assert that any of the disputed services are investigational or experimental.

Review of the submitted information finds no evidence to support a utilization review determination, considering the specific circumstances in this case, to establish the experimental or investigational nature of the compound.

Because the respondent failed to support a determination by utilization review that the compound dispensed to the employee is investigational or experimental, and because the compound contains no drug identified with status N in ODG Appendix A, preauthorization of the disputed compound was not required. As a consequence, the carrier's preauthorization denial is not supported. The disputed compound will therefore be reviewed for payment in accordance with division rules and fee guidelines.

3. This dispute regards a pharmaceutical compound with reimbursement subject to the *Pharmacy Fee Guideline*, 28 Texas Administrative Code §134.503(c), requiring the insurance carrier to reimburse prescription drugs the lesser of: (1) the fee established by formula in the rule based on the average wholesale price (AWP) as reported by nationally recognized pharmaceutical pricing data; or (2) the amount billed.

   Reimbursement is calculated as follows:

Ingredient(s)	NDC & Type	Unit Price	Total Units	AWP Formula §134.503(c)(1)	Billed Amount §134.503(c)(2)	Lesser of (c)(1) or (c)(2)
FLURBIPROFEN	38779036209 Generic	$36.58	6	($36.58 × 6) × 1.25 = $274.35	$219.48	$219.48
MELOXICAM	38779274601 Generic	$194.67	0.2	($194.67 × 0.18) × 1.25 = $43.80	$35.04	$35.04
MEFENAMIC ACID	38779066906 Generic	$123.60	1.8	($123.60 × 1.8) × 1.25 = $278.10	$222.48	$222.48
BACLOFEN	38779038809 Generic	$35.63	3	($35.63 × 3) × 1.25 = $133.61	$106.89	$106.89
BUPIVACAINE HCL	38779052405 Generic	$45.60	1.2	($45.60 × 1.2) × 1.25 = $68.40	$54.72	$54.72
ETHOXY DIGLYCOL	38779190301 Generic	$0.34	3	($0.34 × 3) × 1.25 = $1.28	$1.03	$1.03
VERSAPRO	38779252903 *Brand*	$3.20	45	($3.20 × 44.82) × 1.09 = $156.33	$143.42	$143.42
		Total Units:	60		Subtotal:	$783.06
					+ $15 compound fee = **Total**:	$798.06

The total reimbursement for the medication in dispute is $798.06. The requestor is seeking $798.06. This amount is recommended.

Conclusion

The division emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $798.06.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $798.06, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	December 20, 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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.