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
Property & Casualty Insurance Company of Hartford

MFDR Tracking Number
M4-19-1175-01

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 therefore do not need a retrospective review."

Amount in Dispute: $798.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on this lack of information, the current request is not medically necessary."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 8, 2018	Compound Medication	$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 §133.240 sets out the procedures for payment or denial of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
4. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
5. 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to certified networks.
6. The insurance carrier reduced payment for the disputed services based on preauthorization.

Issues

1. Did the insurance carrier raise a new defense in its response?
2. Is the insurance carrier's reason for denial of payment based on preauthorization supported?
3. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the disputed compound?

Findings

1. Memorial is seeking reimbursement for a compound dispensed on March 8, 2018. In its position statement, The Hartford, on behalf of the insurance carrier, argued that the compound was denied because it was not medically necessary.

   The response from the insurance carrier is required to address only the denial reasons presented to the requestor before the medical fee dispute resolution (MFDR) was filed with the Texas Department of Insurance, Division of Workers' Compensation (DWC). Any new denial reasons or defenses raised shall not be considered in this review.[1]

   The submitted documentation does not support that denials based on medical necessity were provided to Memorial before this request for MFDR was filed. Therefore, the DWC will not consider this argument in the current dispute review.

2. The explanations of benefits submitted for the service specified in this dispute indicates that the insurance carrier denied the compound based on preauthorization. Preauthorization for compounds is only required for:

   - any compound that contains a drug identified with a status of "N" in the current edition of the ODG Appendix A[2]; and
   - any investigational or experimental drug.[3]

   The compound in question does not contain an ingredient identified with a status of "N" in the current edition of the ODG, Appendix A.

   The determination of a service's investigational or experimental nature is determined on a case by case basis through utilization review.[4] The insurance carrier provided no evidence that it engaged in a prospective or retrospective utilization review to establish that the specific compound considered in this review is investigational or experimental. The insurance carrier's preauthorization denial is therefore not supported.

3. Because the insurance carrier failed to sufficiently support its denial of reimbursement, Memorial is entitled to reimbursement.

   The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately.[5] Each ingredient is listed below with its reimbursement amount.[6] The calculation of the total allowable amount is as follows:

[1] 28 Texas Administrative Code §133.307(d)(2)(F)
[2] *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary*
[3] 28 Texas Administrative Code §134.540(b)
[4] Texas Insurance Code §19.2005(b)
[5] 28 Texas Administrative Code §134.502(d)(2)
[6] 28 Texas Administrative Code §134.503(c)

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Flurbiprofen	38779036209	G	$36.58	6	$274.35	$219.48	$219.48
Meloxicam	38779274601	G	$194.67	0.18	$43.80	$35.04	$35.04
Mefenamic Acid	38779066906	G	$126.60	1.8	$284.85	$222.48	$222.48
Baclofen	38779038809	G	$35.63	3	$133.61	$106.89	$106.89
Bupivacaine	38779052405	G	$45.60	1.2	$68.40	$54.72	$54.72
Ethoxy Diglycol	38779052405	G	$0.34	3	$1.28	$1.03	$1.03
Versapro Cream	38779252903	B	$3.20	44.82	$156.33	$143.42	$143.42
Fee	NA	NA	NA	NA	$15.00	$15.00	$15.00
						Total	$798.06

The total allowable for the disputed compound is $798.06. This amount is recommended.

Conclusion

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

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	November 29, 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.