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
Praetorian Insurance Co

MFDR Tracking Number
M4-19-1220-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 2, 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: $702.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company stands on their original review."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 14, 2018	Compound Medication	$702.68	$702.68

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 (DWC).

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 denied payment based on the absence of preauthorization.

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. Is the requestor entitled to reimbursement for the compound in question?

Findings

1. The requestor is seeking reimbursement for a compound dispensed on March 14, 2018. The insurance carrier denied the disputed compound based on preauthorization.

28 TAC 134.530 (b) states in pertinent part 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, *ODG Workers' Compensation Drug Formulary,* any prescription drug created through compounding prescribed before July 1, 2018 that contains a drug identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG), any prescription drug created through compounding prescribed and dispensed on or **after July 1, 2018**, and 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 the submitted documentation found the disputed compound does not contain a drug identified as a "N" drug, is prior to July 1, 2018 and the insurance carrier did not support a determination of investigational and experimental was made at the time of utilization review for the disputed services. The insurance carrier's denial is not supported.

2. 28 Texas Administrative Code §134.503 (c) states in pertinent part 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;
    - 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

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Baclofen	38779038809	G	35.63	5.4	$35.63 x 1.25 x 5.4 = $240.50	$190.78	$190.78
Amantadine	38779041105	G	24.23	3.0	$24.23 x 1.25 x 3 = $92.74	$72.69	$72.69
Gabapentin	38779246109	G	59.85	3.6	$59.85 x 1.25 x 3.6 = $269.33	$204.66	$204.66
Bupivacaine	38779052405	G	45.60	1.2	$45.60 x 1.25 x 1.2 = $68.40	$54.72	$54.72
Amitriptyline	38779018904	G	18.24	1.8	$18.24 x 1.25 x 1.8 = $41.04	$32.83	$32.83
Ethoxy Diglycol	38779190301	G	0.34	4.2	$0.34 x 1.25 x 4.2 = $1.79	$1.44	$1.44
Versapro Cream	38779252903	B	3.20	40.8	$3.20 x 1.09 x 40.8 = $142.31	$130.56	$130.56
Compounding fee	n/a	n/a				$15.00	$15.00
						Total	$702.68

The total reimbursement is therefore $702.68. This amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $702.68.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services.
The DWC hereby ORDERS the respondent to remit to the requestor $702.68, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		January 31, 2020
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the 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.