



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

Insurance Co of the State of PA

MFDR Tracking Number

M4-19-1223-01

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: \$798.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...the resulting medication is not part of the closed formulary and requires preauthorization."

Response Submitted by: Ricky D Green

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 29, 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 (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. 28 Texas Administrative Codes §§134.530 and 134.540 sets out the closed formulary requirements, effective January 17, 2011, 35 TexReg 11344.
5. 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 29, 2018. The insurance carrier denied the disputed compound based on preauthorization. Preauthorization is only required for:
 - drugs identified with a status of “N” in the current edition of the ODG Appendix A¹;
 - any compound that contains a drug identified with a status of “N” in the current edition of the ODG Appendix A; and
 - any investigational or experimental drug.²

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 respondent argues “Although each drug listed individually is FDA approved, none of the drugs listed in the request for reimbursement are FDA approved to be taken or applied in a topical dosage form. Secondly, the FDA does not recognize or approve the resulting mixture or compound of two or more of the drugs at issue in any dosage form, be it oral, topical, or otherwise. As such, the resulting medication is not part of the closed formulary and requires preauthorization.”

The preamble relating to the adoption of relevant pharmacy rules clearly states that the DWC intended for the ingredients of the compound to drive preauthorization requirements, not compounds as a class.³

The respondent provided no evidence that the insurance carrier engaged in a prospective or retrospective utilization review to establish that the specific compound considered in this review required preauthorization based on lack of FDA approval. The insurance carrier’s denial is not supported.

2. The calculation of the total allowable amount is as follows:⁴

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	$\$36.58 \times 1.25 \times 6 =$ \$274.35	\$219.48	\$219.48
Meloxicam	38779274601	G	\$194.67	0.18	$\$194.67 \times 1.25 \times 0.18 =$ \$43.80	\$35.04	\$35.04
Mefenamic Acid	38779066906	G	\$123.60	1.8	$\$123.60 \times 1.25 \times 1.8 =$ \$278.10	\$222.48	\$222.48
Baclofen	38779038809	G	\$35.63	3	$\$35.63 \times 1.25 \times 3 =$ \$133.61	\$106.89	\$106.89
Bupivacaine	38779052405	G	\$45.60	1.2	$\$45.60 \times 1.25 \times 1.2 =$ \$68.40	\$54.72	\$54.72
Ethoxy Diglycol	38779190301	G	\$0.342	3	$\$0.342 \times 1.25 \times 3 =$ \$1.28	\$1.03	\$1.03
Versapro Cream	38779252903	B	\$3.20	44.82	$\$3.20 \times 1.09 \times 44.82 =$ \$156.33	\$143.42	\$143.42
Compounding fee	n/a	n/a				\$15.00	\$15.00
						Total	\$798.06

¹ ODG Treatment in Workers’ Comp (ODG) / Appendix A, ODG Workers’ Compensation Drug Formulary

² 28 Texas Administrative Codes §§134.530 (b)(1) 134.540 (b)

³ The Division initially considered requiring preauthorization for all compound drugs. However, with stakeholder feedback and, in the interest of curbing the expense of numerous preauthorization requests, the Division reconsidered and adopts a more measured approach as specified in the proposal, which is requiring preauthorization only for those compounds that contain an “N” drug. The Division notes that an insurance carrier has the ability to conduct retrospective utilization review for all compounds not containing an “N” drug so that insurance carriers have the ability to only pay for medically necessary care. [http://texreg.sos.state.tx.us/public/regviewer\\$ext.RegPage?sl=T&app=2&p_dir=F&p_rloc=231643&p_tloc=98652&p_ploc=78924&pg=6&p_reg=201006879&ti=&pt=&ch=&rl=&z_chk=53523](http://texreg.sos.state.tx.us/public/regviewer$ext.RegPage?sl=T&app=2&p_dir=F&p_rloc=231643&p_tloc=98652&p_ploc=78924&pg=6&p_reg=201006879&ti=&pt=&ch=&rl=&z_chk=53523)

⁴ 28 Texas Administrative Code §134.503(c)

The total reimbursement is therefore \$798.06. 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 \$798.06.

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 \$798.06, 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.