TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
Liberty Mutual Fire Insurance Co

MFDR Tracking Number
M4-19-1317-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
November 5, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the reconsideration based on lack of preauthorization or preauthorization was absent. These medications do not require preauthorization therefore do not need a retrospective review."

Amount in Dispute: $569.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The 3/26/18 compounded medication was not denied as requiring preauthorization, as investigational or as experimental. It was denied as not medically necessary following completion of a retrospective medical necessity review."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 26, 2018	Pharmacy Services - Compounds	$569.93	$569.93

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 guidelines for pharmaceutical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 388 – Pre-authorization was requested but denied for this service per DWC Rule 134.600

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 of $569.93 for a compound dispensed March 26, 2018. The insurance carrier denied the disputed compound with claim adjustment reason code 388 – "Pre-authorization was requested but denied for this service per DWC Rule 134.600."

   For the dates of service in dispute the applicable rule is 28 TAC §134.530(b)(1)(A) which states that 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,* and any updates;
   - any compound that contains a drug 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,* and any updates; 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).

   DWC finds that the compound rendered on the date of service in question does not include a drug identified with a status of "N" in the current edition of the ODG, *Appendix A*. Therefore, the division concludes that the compound in question did not require preauthorization and the carrier's denial of payment for this reason is not supported. Therefore, the disputed compound will be reviewed for reimbursement.

2. 28 TAC §134.503 applies to the compounds in dispute and states, in pertinent part:

   (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
   (1) 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:
   (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
   (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;
   (C) 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

   The reimbursement is calculated as follows:

Ingredient	NDC	Price/ Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Gabapentin	38779246109	$59.85	3	$224.44	$179.55	$179.55
Amitriptyline	38779018904	$18.24	2.4	$54.72	$43.78	$43.78
Amantadine	38779041105	$24.23	4.8	$145.35	$116.30	$116.30
Flurbiprofen	38779036209	$36.58	4.8	$219.48	$175.58	$175.58
Bupivacaine	38779052405	$45.60	1.2	$68.40	$54.72	$54.72
					Total	$569.93

The total reimbursement is $569.93. This amount is recommended.

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 $569.93.

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 $569.93, 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 7, 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.