



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

Electric Insurance Co

MFDR Tracking Number

M4-19-1335-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

November 8, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Texas Labor Code Section 408.027 (b) requires that the carrier must pay, reduce, deny or determine to audit the health provider's claim no later than the 45th day after the date of receipt by the carrier. Memorial did not receive any correspondence as per rule..."

Amount in Dispute: \$1,065.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The compound medication in dispute in this matter was denied based on retrospective medical necessity. The peer review report is attached."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: June 16, 2018, Lenzapatch, Pharmacy Services - Compounds, \$1,065.56, \$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 guidelines for pharmaceutical services.
3. 28 Texas Administrative Code §133.240 sets out requirements of adverse determinations.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
• 197 - "Payment denied/reduced for absence of precertification/authorization"

Issues

1. Did the insurance carrier raise a new defense?
2. Is the insurance carrier's reason for denial of payment supported?
3. Is the requestor entitled to reimbursement for the compound in question?

Findings

1. The insurance carrier states in their position statement, "The compound medication in dispute in this matter was denied based on retrospective medical necessity."

28 Texas Administrative Code §133.307(d)(2)(F) states, in relevant part, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

Review of the submitted documentation finds that insurance carrier failed to present a medical necessity denial to health care provider in accordance with 28 Texas Administrative Code §133.240 prior to the date the request for medical fee dispute resolution (MFDR) was filed. The division concludes that this defense presented in respondent's position statement will not be considered for review pursuant to 28 Texas Administrative Code §133.307(d)(2)(F).

2. The requestor is seeking reimbursement of \$798.06 for a compound pharmacy service dispensed June 16, 2018 and the medication Lenzapatch also dispensed June 16, 2018. The carrier denied the disputed claims with adjustment reason code 197 – "Payment denied/reduced for absence of precertification/authorization."

For the dates of service in dispute the applicable rule is 28 Texas Administrative Code §134.530 (b) 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).

The division 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*. However, the medication Lenzapatch is comprised of "Lidocaine." Review of the ODG, *Appendix A* finds Lidocaine is a "N" drug and the carrier's denial for lack of preauthorization is supported.

The compound in question did not require preauthorization and the carrier's denial of payment for this reason is not supported. The disputed compound will be reviewed for reimbursement.

3. 28 Texas Administrative Code §134.503 (c) applies to the compound 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 \text{ per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;
 - (B) Brand name drugs: $((AWP \text{ per unit}) \times (\text{number of units}) \times 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;

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)
Flurbiprofen	38779036209	\$36.58	6	\$274.35	\$219.48	\$219.48
Meloxicam	38779274601	\$194.68	0.18	\$43.80	\$35.04	\$35.04
Mefenamic Acid	38779066906	\$123.60	1.8	\$278.10	\$222.48	\$222.48
Baclofen	38779038809	\$35.63	3	\$133.61	\$106.89	\$106.89
Bupivacaine	38779052405	\$45.60	1.2	\$68.40	\$54.72	\$54.72
Ethoxy Diglycol	38779190301	\$45.60	1.2	\$68.40	\$1.03	\$1.03
Versapro Cream	38779252903	\$3.20	44.82	\$156.33	\$143.42	\$143.42
Compounding Fee	NA	\$15.00	1	NA	\$15.00	\$15.00
					Total	\$798.06

The total reimbursement is \$798.06. This amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been 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

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.