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
SAFETY NATIONAL CASUALTY CORPORATION

MFDR Tracking Number
M4-19-1385-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 8, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial Compounding Pharmacy has met the requirements to receive reimbursement."

Amount in Dispute: $702.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Pre-authorization is required based on State of TX rules: 28 TAC 134.530. (D). any investigational or experimental drug …"

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 27, 2018	Pharmaceutical Compound	$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.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.500 defines words and terms relating to pharmaceutical benefits.
3. 28 Texas Administrative Code §134.503 sets out the fee guideline for pharmacy services.
4. 28 Texas Administrative Code §134.530 sets out closed formulary requirements for non-network claims.
5. 28 Texas Administrative Code §19.2005 sets out general standards of utilization review.
6. Texas Insurance Code §4201.002 defines words and terms related to utilization review.
7. The insurance carrier denied payment based on the following claim adjustment codes:
   - 197 – Precertification/authorization absent
   - W3 – Additional payment made on appeal/reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted legislated fee arrangement.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Was preauthorization required?
2. What is the recommended reimbursement for the disputed pharmaceutical compound?

Findings

1. The requestor is seeking reimbursement for a compounded medication dispensed on April 27, 2018.

   The insurance carrier denied payment using denial reason code: 197 – “Precertification/authorization absent.”

   Rule §134.500(3) defines the division’s closed formulary to include all available FDA approved drugs prescribed for outpatient use, with certain exclusions. Rule §134.530(b)(1) requires preauthorization only for:

   - drugs identified with status N in the current edition of ODG Appendix A[1];
   - compounds containing a drug identified with status N in the current edition of ODG Appendix A; and
   - any investigational or experimental drug.

   The disputed compound contains only FDA approved drugs not identified with status N in ODG Appendix A.

   The respondent asserts, however, “Preauthorization is required based on State of TX rules: 28 TAC 134.530. (D). any investigational or experimental drug …”

   Whether a service is investigational or experimental must be determined on a case-by-case basis by utilization review — considering any special circumstances that require deviation from screening criteria or guidelines.[2] Utilization review includes a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of the health care.[3]

   Review of the submitted information finds no evidence to support a utilization review determination, considering the specific circumstances in this case, to establish the experimental or investigational nature of the compound.

   Because the respondent failed to support utilization review of the compound dispensed to the employee, the disputed compound cannot be deemed experimental or investigational. Accordingly, preauthorization of the disputed compound was not required. As a consequence, the carrier’s preauthorization denial is not supported.

   The disputed compound will therefore be reviewed for payment in accordance with division rules and fee guidelines.

2. This dispute regards a pharmaceutical compound with reimbursement subject to the *Pharmacy Fee Guideline*, 28 Texas Administrative Code §134.503(c), requiring the insurance carrier to reimburse prescription drugs the lesser of: (1) the fee established by formula in the rule based on the average wholesale price (AWP) as reported by nationally recognized pharmaceutical pricing data; or (2) the amount billed.

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[1] *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary*

[2] 28 Texas Administrative Code §19.2005(b)

[3] Texas Insurance Code §4201.002(13)

Reimbursement is calculated as follows:

Ingredient(s)	NDC & Type	Unit Price	Total Units	AWP Formula §134.503(c)(1)	Billed Amount §134.503(c)(2)	Lesser of (c)(1) or (c)(2)
BACLOFEN	38779038809 Generic	$35.63	5	($35.63 × 5.4) × 1.25 = $240.50	$190.78	$190.78
AMANTADINE HCL	38779041105 Generic	$24.23	3	($24.23 × 3) × 1.25 = $90.84	$72.69	$72.69
GABAPENTIN	38779246109 Generic	$59.85	4	($59.85 × 3.6) × 1.25 = $269.33	$204.66	$204.66
BUPIVACAINE HCL	38779052405 Generic	$45.60	1	($45.60 × 1.2) × 1.25 = $68.40	$54.72	$54.72
AMITRIPTYLINE HCL	38779018904 Generic	$18.24	2	($18.24 × 1.8) × 1.25 = $41.04	$32.83	$32.83
ETHOXY DIGLYCOL	38779190301 Generic	$0.34	4	($0.34 × 4.2) × 1.25 = $1.80	$1.44	$1.44
VERSAPRO	38779252903 *Brand*	$3.20	40.8	($3.20 × 40.8) × 1.09 = $142.31	$130.56	$130.56
		Total Units:	60		Subtotal:	$687.68
					+ $15 compound fee = **Total**:	$702.68

The total reimbursement for the medication in dispute is $702.68. This amount is recommended.

Conclusion

The division emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division finds that the requestor has /has not 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 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 $702.68, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	December 7, 2018
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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.