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
OLD REPUBLIC INSURANCE COMPANY

MFDR Tracking Number
M4-19-1458-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
November 15, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "There is no PLN11 attached that was processed prior to services being rendered."

Amount in Dispute: $798.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Pre-Authorization is required based on State of TX rules: 28 TAC 134.530. (D)."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 17, 2018	Pharmaceutical Compound	$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.

Background

1. 28 Texas Administrative Code Chapter 19, Subchapter U sets out rules for utilization review of health care.
2. 28 Texas Administrative Code §19.2005 sets out general standards of utilization review.
3. 28 Texas Administrative Code §124.2 sets out requirements for carrier reporting and notification.
4. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
5. 28 Texas Administrative Code §134.500 defines words and terms relating to pharmaceutical benefits.
6. 28 Texas Administrative Code §134.503 sets out the fee guideline for pharmacy services.
7. 28 Texas Administrative Code §134.530 sets out closed formulary requirements for non-network claims.
8. Texas Insurance Code §4201.002 defines words and terms related to utilization review.
9. Texas Labor Code §408.021 entitles an injured employee to all required health care as and when needed.
10. The insurance carrier denied payment based on the following claim adjustment codes:
    - 219 – Based on extent of injury.
    - 197 – Precertification/authorization/notification absent.
    - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
    - P12 – Workers' compensation jurisdictional fee schedule adjustment.
    - W3 – Request for reconsideration.
    - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Are there any unresolved issues regarding the extent of injury?
2. Was preauthorization required?
3. What is the recommended reimbursement for the disputed pharmaceutical compound?

Findings

1. The insurance carrier denied payment for the disputed compound with claim adjustment code 219 – "Based on extent of injury."

   The insurance carrier did not maintain this denial reason in the respondent's position statement.

   Rule §124.2(h) requires notification to the division and claimant of any dispute of disability or extent of injury using plain language notices with language and content prescribed by the division. Such notices "shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim."

   Rule §133.307(d)(2)(H) further requires that If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with Rule §124.2 (relating to carrier reporting and notification requirements).

   Review of the submitted information finds no copies, as required by Rule $133.307(d)(2)(H), of any PLN-11 or plain language notices issued in accordance with Rule §124.2.

   The insurance carrier's extent of injury denial is not supported. Moreover, because the respondent did not provide documentation to MFDR of any notice of such extent issues, the respondent failed to meet the requirements of Rule §133.307(d)(2)(H) and has thus waived the right to raise such issues during dispute resolution. Consequently, the division concludes there are no outstanding issues of extent. The dispute is therefore eligible for review.

2. The insurance carrier also denied payment for the disputed compound based on the absence of preauthorization.

   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, "Pre-Authorization is required based on State of TX rules: 28 TAC 134.530. (D). any investigational or experimental drug … Research below:"

   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]

   Labor Code §408.021(a) entitles an injured employee to all health care required by the nature of the injury as and when needed, including health care that cures or relieves the effects of the injury; promotes recovery; or enhances the ability to return to or retain employment.

   In the adoption preamble to 28 Texas Administrative Code Chapter 19, Subchapter U, the division emphasized: "an injured employee under both network and non-network coverage is entitled to all medically necessary health care services, including experimental and investigational health care services." [4]

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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)
[4] ADOPTED RULES February 15, 2013, 38 *Texas Register* 895

While investigational or experimental services require preauthorization, no service may be deemed investigational or experimental absent review by a licensed UR agent, as expressly stated in the preamble to Subchapter U:

> Even though the determination that a health care service is experimental or investigational does not in itself constitute an adverse determination, only a URA should make determinations that health care services are experimental or investigational, based on the definition of "utilization review." [4]

The research presented by the respondent did not involve a utilization review determination. The research did not discuss or support that the compound or any component of the compound was investigational or experimental. The submitted documentation does not support that preauthorization was required.

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. The compound did not contain a drug identified with status N in the ODG Appendix A. Accordingly, preauthorization of the disputed compound was not required. As a consequence, the insurance carrier's preauthorization denial is not supported.

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

3. 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.

   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)
FLURBIPROFEN	38779036209 Generic	$36.58	6	($36.58 × 6) × 1.25 = $274.35	$219.48	$219.48
MELOXICAM	38779274601 Generic	$194.67	0.2	($194.67 × 0.18) × 1.25 = $43.80	$35.04	$35.04
MEFENAMIC ACID	38779066906 Generic	$123.60	1.8	($123.60 × 1.8) × 1.25 = $278.10	$222.48	$222.48
BACLOFEN	38779038809 Generic	$35.63	3	($35.63 × 3) × 1.25 = $133.61	$106.89	$106.89
BUPIVACAINE HCL	38779052405 Generic	$45.60	1.2	($45.60 × 1.2) × 1.25 = $68.40	$54.72	$54.72
ETHOXY DIGLYCOL	38779190301 Generic	$0.34	3	($0.34 × 3) × 1.25 = $1.28	$1.03	$1.03
VERSAPRO	38779252903 *Brand*	$3.20	45	($3.20 × 44.82) × 1.09 = $156.33	$143.42	$143.42
		Total Units:	60		Subtotal:	$783.06
					+ $15 compound fee = **Total**:	$798.06

   The total reimbursement for the medication in dispute is $798.06. This amount is recommended.

Conclusion

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

	Grayson Richardson	December 20, 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.