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
Hartford Underwriters Insurance Co

MFDR Tracking Number
M4-19-1473-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
November 15, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial Compounding is an approved provider and should be reimbursed accordingly. The referral provider has been treating the patient for the injury sustained at work."

Amount in Dispute: $871.73

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The records submitted for review would not support the requested compounded medication as reasonable or necessary."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 12, 2018	Compounded pharmacy	$726.32	$0.00
April 12, 2018	Tizanidine HCL 4mg tablet	$145.41	$109.88

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 pharmacy fee guideline.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 71 – Prescriber is not covered

Issues

1. Is the dispute for compound pharmacy services eligible for review?
2. Is the insurance carrier's reason for denial of payment of the oral medication supported?

Findings

1. The requestor is seeking reimbursement for a compounded medication and an oral medication. Each medication will be discussed separately.

   The respondent states, "The records submitted for review would not support the requested compounded medication as reasonable or necessary."

   28 TAC §133.307 (d)(2)(I) states,

   > (I) If the medical fee dispute involves medical necessity issues, the insurance carrier shall attach a copy of documentation that supports an adverse determination in accordance with §19.2005 of this title (relating to General Standards of Utilization Review).

   Review of the submitted documentation found a notice of adverse determination for the compound medication that states, "…the services or treatment described below are not medically necessary or appropriate." The insurance carrier notified the requestor their ability to appeal this medical necessity denial.

   Based on the information available to DWC, the dispute regarding the compound medication is not eligible for review per 28 TAC §133.307(d)(2)(F) which states in pertinent part, "If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section." Based on the adverse determination based on medical necessity, the compound in dispute will not be reviewed.

2. The insurance carrier denied the oral medication based on the non-eligibility of the prescriber. Insufficient evidence was found to support this denial. This service will be reviewed per applicable DWC rules and fee guidelines.

   28 TAC 134.503 (c) (1) (A) and (B) states,
   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;

   The allowable is calculated as follows;

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Tizanidine	60505025202	G	$1.47	60	$109.88	$145.41	$109.88

The allowable of $109.88 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $109.88.

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 $109.88, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

	Peggy Miller	June 6, 2019
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 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.