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
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-19-1559-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
November 16, 2018

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $726.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The lack of FDA approval of this compound cream means it is not included in the closed formulary, requiring preauthorization. …This compound formulation is also investigation or experimental, requiring preauthorization."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 28, 2018	Compound Medication	$726.62	$726.62

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 (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. 28 Texas Administrative Codes §§134.530 and 134.540 sets out the closed formulary requirements, effective January 17, 2011, 35 TexReg 11344.

5. The insurance carrier denied payment based on the absence of preauthorization.

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 for a compound dispensed on May 28, 2018. The insurance carrier denied the disputed compound based on preauthorization. Preauthorization is only required for:
   - drugs identified with a status of "N" in the current edition of the ODG Appendix A[1];
   - any compound that contains a drug identified with a status of "N" in the current edition of the ODG Appendix A; and
   - any investigational or experimental drug.[2]

   The compound in question does not contain an ingredient identified with a status of "N" in the current edition of the ODG, Appendix A.

   The respondent argued that "This compound formulation is also investigation or experimental, requiring preauthorization."

   The determination of a service's investigational or experimental nature is determined on a case by case basis through utilization review.[3] Utilization review, includes a prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services.[4]

   The preamble relating to the adoption of relevant pharmacy rules clearly states that the DWC intended for the ingredients of the compound to drive preauthorization requirements, not compounds as a class.[5]

   The respondent provided no evidence of a prospective or retrospective utilization review to establish that the specific compound is considered investigational or experimental.

   The requirement for preauthorization based on the compound is investigational or experimental is not triggered in this case. The insurance carrier's preauthorization denial is not supported.

2. The calculation of the total allowable amount is as follows:

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Meloxicam	38779274601	G	$194.67	0.18	$194.67 x 1.25 x 0.18 = $43.80	$35.04	$35.04
Flurbiprofen	38779036209	G	$36.58	4.8	$36.58 x 1.25 x 4.8 = $219.48	$175.58	$175.58
Tramadol	38779237409	G	$36.30	6	$36.30 x 1.25 x 6 = $272.25	$217.80	$217.80
Cyclobenzaprine	38779039509	G	$46.33	1.8	$46.33 x 1.25 x 1.8 = $104.24	$83.39	$83.39
Bupivacaine	38779052405	G	$45.60	1.2	$45.60 x 1.25 x 1.2 = $68.40	$54.72	$54.72
Ethoxy Diglycol	38779190301	G	$0.342	3	$0.342 x 1.25 x 3 = $1.28	$1.03	$1.03
Versapro Cream	38779252903	B	$3.20	44.82	$3.20 x 1.09 x 44.82 = $156.33	$144.40	$144.06
Compounding fee	n/a	n/a				$15.00	$15.00
						Total	$726.62

[1] *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary*
[2] 28 Texas Administrative Codes §§134.530 (b)(1) 134.540 (b)
[3] Texas Insurance Code §19.2005 (b)
[4] Texas Insurance Code §4201.002 (13)
[5] The Division initially considered requiring preauthorization for all compound drugs. However, with stakeholder feedback and, in the interest of curbing the expense of numerous preauthorization requests, the Division reconsidered and adopts a more measured approach as specified in the proposal, which is requiring preauthorization only for those compounds that contain an "N" drug. The Division notes that an insurance carrier has the ability to conduct retrospective utilization review for all compounds not containing an "N" drug so that insurance carriers have the ability to only pay for medically necessary care. http://texreg.sos.state.tx.us/public/regviewer$ext.RegPage?sl=T&app=2&p_dir=F&p_rloc=231643&p_tloc=98652&p_ploc=78924&pg=6&p_reg=201006879&ti=&pt=&ch=&rl=&z_chk=53523

The total reimbursement is $726.62. This amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $726.62.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services.
The DWC hereby ORDERS the respondent to remit to the requestor $726.62, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		January 30, 2020
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.