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
REDWOOD FIRE & CASUALTY INSURANCE COMPANY

MFDR Tracking Number
M4-19-1655-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
November 20, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "we submitted the original bill and then requested the carrier review bill again and we still did not get a response."

Amount in Dispute: $702.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier denies payment for the compounded medications because they were not medical necessary. Carrier further asserts that preauthorization for the compound drugs was required, but not sought, by Memorial. Finally, Carrier contends that the cost of the prescription compound was excessive and unreasonable."

Response Submitted by: Stone Loughlin Swanson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
July 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 §124.2 sets out requirements for carrier reporting and notification.
3. 28 Texas Administrative Code §134.500 defines words and terms relating to pharmaceutical benefits.
4. 28 Texas Administrative Code §134.503 sets out the fee guideline for pharmacy services.
5. 28 Texas Administrative Code §134.530 sets out closed formulary requirements for non-network claims.
6. 28 Texas Administrative Code §134.600 sets out rules related to preauthorization of health care.
7. 28 Texas Administrative Code Chapter 19, Subchapter U sets out rules for utilization review of health care.
8. 28 Texas Administrative Code §19.2005 sets out general standards of utilization review.
9. Texas Insurance Code §4201.002 defines words and terms related to utilization review.
10. Texas Labor Code §408.021 entitles an injured employee to all required health care as and when needed.
11. The insurance carrier denied payment based on the following denial reason (no adjustment code given):
    - The procedure or supply requires prior authorization or approval.

Issues

1. Was preauthorization required?
2. Did the respondent raise new denial reasons or defenses in their response to MFDR?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied payment for the disputed compound based on "The procedure or supply requires prior authorization or approval. The respondent's MFDR position statement asserts that "Under Rule §134.600(p)(11), non-emergency health care requiring preauthorization 'includes drugs not included in the applicable division formulary.'"

   Rule §134.500(3) defines the division's closed formulary to include all available Food and Drug Administration (FDA) approved prescription and nonprescription drugs prescribed and dispensed for outpatient use, excluding drugs — or any prescription drug created through compounding prescribed before July 1, 2018 that contains a drug — identified with a status of "N" in the current edition of the Official Disability Guidelines 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).

   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.

   Furthermore, Rule §134.530(b)(2) states that when Rule §134.600(p)(12) … conflicts with this section [28 Texas Administrative Code§134.530], this section [§134.530] prevails.

   Review of the submitted information finds that the disputed compound contains only FDA approved drugs not identified with status N in ODG Appendix A. Accordingly, the division concludes that the compound and all the component drugs were included in the division's pharmaceutical formulary.

   No information was presented to support that any of the component drugs were investigational or experimental.

   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] And 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]

[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

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 carrier 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 insurance carrier has failed to support its denial reason. The disputed compound will therefore be reviewed for payment in accordance with division rules and fee guidelines.

2. Review of the insurance carrier's response finds new denial reasons or defenses raised that were not presented to the requestor before the filing of the request for medical fee dispute resolution.

   Rule §133.307(d)(2)(B) requires that upon receipt of the request for medical fee dispute resolution, the respondent shall provide any missing information not provided by the requestor and known to the respondent, including:

   > a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider . . . related to the health care in dispute not submitted by the requestor or a statement certifying that the respondent did not receive the health care provider's disputed billing prior to the dispute request.

   Review of the submitted information finds no documentation to support any EOBs were presented to the health care provider giving notice of the new denial reasons or defenses raised in the insurance carrier's response to MFDR.

   Rule §133.307(d)(2)(F) requires that:

   > 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.

   Pursuant to Rule §133.307(d)(2)(F), the insurance carrier's failure to give notice to the health care provider of specific codes or explanations for reduction or denial of payment as required by Rule §133.240 constitutes grounds for the division to find a waiver of defenses during Medical Fee Dispute Resolution.

   Upon review of the insurance carrier response, the division finds the respondent has raised new denial reasons or defenses of which the carrier failed to give any notice to the health care provider during the bill review process or before the filing of this dispute. Consequently, the division concludes the insurance carrier has waived the right to raise such new denial reasons or defenses during dispute resolution. Any such new defenses or denial reasons will not be considered in this review.

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. Payment 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	5.4	($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	3.6	($59.85 × 3.6) × 1.25 = $269.33	$204.66	$204.66
BUPIVACAINE HCL	38779052405 Generic	$45.60	1.2	($45.60 × 1.2) × 1.25 = $68.40	$54.72	$54.72
AMITRIPTYLINE HCL	38779018904 Generic	$18.24	1.8	($18.24 × 1.8) × 1.25 = $41.04	$32.83	$32.83
ETHOXY DIGLYCOL	38779190301 Generic	$0.34	4.2	($0.34 × 4.2) × 1.25 = $1.80	$1.44	$1.44
VERSAPRO	38779252903 *Brand*	$3.20	41	($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

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

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 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 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.