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
Ace American Insurance Co

MFDR Tracking Number
M4-16-1099-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
December 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached bills were denied by the carrier stating preauthorization was not obtained."

Amount in Dispute: $495.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In conclusion, no reimbursement should be awarded to Requestor for the billed medication because the medication was denied as not medically necessary prior to the medication being filled."

Response Submitted by: Downs ♦ Stanford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 28, 2015	Mefenamic Acid, Baclofen, Flurbiprofen, Meloxicam	$495.44	$495.44

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 §134.530 sets out the requirements for use of the closed formulary for claims not subject to certified networks.
3. 28 Texas Administrative Code §134.503 sets out the pharmacy fee guidelines
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - D46 – Claim/service denied/reduced for absence of, or exceeded, pre-certification/authorization
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline

Issues

1. Is the carrier's pre-authorization denial supported?
2. Is the carrier's medical necessity denial supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code D46 – "Claim/service denied/reduced for absence of, or exceeded, pre-certification/authorization." 28 Texas Administrative Code §134.530(b) (1) states, in pertinent part,

> Preauthorization is only required for:
>
> (A) drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates;
>
> (B) any compound that contains a drug identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates; and
>
> (C) 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).

The service in dispute is a compound medication containing Mefenamic Acid, Baclofen, Flurbiprofen, and Meloxicam, therefore §134.503 (b)(1)(B) applies.

Review of Appendix A, ODG Workers' Compensation Drug Formulary finds that the services in dispute were each found to be a "Y" drug not an "N" drug.

Pursuant to Rule 134.503(b)(1)(A), the insurance carrier's denial reason is not supported.

The Division concludes that preauthorization was not required for service in dispute. For that reason, the division finds the carrier's preauthorization denial is not supported.

2. The respondent states in their position statement, "The compound mediation was reviewed by two physician reviewers *prior* to the date the medication was filled. Both found the medication was not medically necessary. Both opined that since the evidence-based guidelines showed one ingredient was not medically necessary because the ingredient was not approved for topical use, then the entire compound cream was not medically necessary."

   28 Texas Administrative Code §134.530 (g) states

> Except as provided in subsection (f)(1) of this section, drugs that do not require preauthorization are subject to **retrospective review** [emphasis added] for medical necessity in accordance with §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) and §133.240 of this title (relating to Medical Payments and Denials), and applicable provisions of Chapter 19 of this title.
>
> (1) Health care, including a prescription for a drug, provided in accordance with §137.100 of this title is presumed reasonable as specified in Labor Code §413.017, and is also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a).
>
> (2) In order for an insurance carrier to deny payment subject to a retrospective review for pharmaceutical services that are recommended by the division's adopted treatment guidelines, §137.100 of this title, the denial must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established under Labor Code §413.017.

   Although the carrier provided evidence of a Peer Review that occurred in January 2015, it provided no evidence to support that a retrospective review that complies with Chapter 19, subchapter U was conducted

for the service in dispute; nor did the carrier assert a denial of payment due to an adverse determination of medical necessity on the explanation of benefits **for the service in dispute** as required pursuant to Rule §133.240(q). The division concludes that the carrier failed to support its position statement.

3. 28 Texas Administrative Code §134.503(c) 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;

   (C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection;

The maximum allowable reimbursement will be calculated as follows:

Date of Service	Service in Dispute	Units	Amount Billed	MAR
January 28, 2015	Mefenamic Acid	2	$146.90	$123.60000 x 2 x 1.25 = $309.00
January 28, 2015	Baclofen	3	$102.60	$35.6300 x 3 x 1.25 = $133.61
January 28, 2015	Flurbiprofen	6	$210.90	$36.5800 x 6 x 1.25 = $274.36
January 28, 2015	Meloxicam	1	$35.04	$35.04 x 1 x 1.25 = $43.80
				a single compounding fee of $15 per prescription
		Total	$495.44	$775.77

The total allowable for the services in dispute is $775.77. The requestor is seeking $495.44. 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 $495.44.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $495.44 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 28, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 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 with the Division. **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.