



# 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**

American Zurich Insurance Co

**MFDR Tracking Number**

M4-18-1425-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

January 17, 2018

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "As of today, we still haven't received any correspondences."

**Amount in Dispute:** \$702.68

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The Requestor did not request and receive preauthorization for this investigational or experimental compound formulation..."

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 29, 2017	Compounded pharmacy	\$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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.240 details the requirements of utilization review.
- 28 Texas Administrative Code §134.503 sets out the reimbursement guidelines for pharmacy services.
- 28 Texas Administrative Code §134.530 sets out requirements for pharmacy prior authorization.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 197 – Precertification/authorization/notification absent

## Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

## Findings

The respondent raised issues of investigational and experimental in their position statement. 28 TAC §133.307 (d)(2)(F) limits DWC MFDR to consider 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.

Review of the submitted explanation of benefits found only a denial for lack of authorization met the requirements of above. This will be the only denial reviewed.

The requestor is seeking reimbursement of pharmacy services rendered on August 29, 2017. The insurance carrier denied disputed services based of lack of preauthorization.

1. 28 TAC §134.530 (b)(1)(A)(B)(C) states preauthorization is required when a drug identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A is prescribed, any prescription drug created through compounding prescribed before July 1, 2018 that contains a drug identified with a status of "N", or 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).

Review of the submitted disputed services found none of the medication listed is identified as a "N" drug and no documentation to support a finding of investigational and experimental that meets the requirements of 28 TAC §133.240 (p) or utilization review.

The services will be reviewed per applicable fee guidelines.

2. 28 TAC 134.503 (c) states the reimbursement for prescription drugs is the lesser of 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 or the providers billed amount:
  - Generic drugs:  $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.25)$
  - Brand name drugs:  $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.09)$
  - For compounds a single fee of \$15.00 is added

The calculation of the dispensed medication based on the above is as follows

Medication	NDC	Units	AWP	MAR	Billed amount
Baclofen	38779038809	5.4	\$35.63	$\$35.63 \times 1.25 \times 5.4 = \$240.50$	\$190.78
Amantadine	38779041105	3	\$24.225	$\$24.225 \times 1.25 \times 3 = \$90.84$	\$72.69
Gabapentin	38779246109	3.6	\$59.85	$\$59.85 \times 1.25 \times 3.6 = \$269.33$	\$204.66
Bupivacaine	38779052405	1.2	\$45.60	$\$45.60 \times 1.25 \times 1.2 = \$68.40$	\$54.72
Amitriptyline	38779018904	1.8	\$18.24	$\$18.24 \times 1.25 \times 1.8 = \$41.04$	\$32.83
Ethoxy Diglycol	38779190301	4.2	\$.342	$\$.342 \times 1.25 \times 4.2 = \$1.80$	\$1.44
Versapro Cream	38779252903	40.8	\$3.20	$\$3.20 \times 1.09 \times 40.8 = \$142.31$	\$130.56
Compounding fee	n/a	1	n/a	\$15.00	\$15.00
			Total	\$869.22	\$702.68

3. The fee schedule amount is \$702.68. This amount is recommended.

**Conclusion**

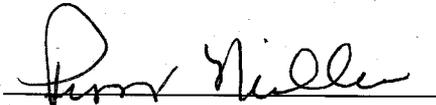
In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established payment is due. As a result, the amount ordered is \$702.68.

**ORDER**

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor \$702.68, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

  
Signature

\_\_\_\_\_  
Peggy Miller  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
December 19, 2019  
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to 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.**