



# 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**

ACE American Insurance Company

**MFDR Tracking Number**

M4-18-2590-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

March 15, 2018

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "These medications do not require preauthorization therefore do not need a retrospective review."

**Amount in Dispute:** \$702.68

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The charges submitted by the Requestor were for the following medications: Baclofen; Amantadine HCL; Gabapentin USP; Bupivacaine HCL; and Amitriptyline HCL ... The medications were not preauthorized and the charges were properly denied. Memorial Compounding RX also requested reconsideration of three charges for Ethoxy Diglyclo; Versapro cream; and compounding fee. There is no evidence that these charges were ever submitted or denied and Memorial Compounding RX has not met the prerequisites for payment."

**Response Submitted by:** Smith & Carr, P.C.

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 26, 2017	Pharmaceutical Compound	\$702.68	\$555.68

### 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 §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 Code §134.530 sets out the closed formulary requirements for claims not subject to

certified networks.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- 197 – Precertification/authorization/notification absent.

### **Issues**

1. Is the insurance carrier’s denial of payment based on preauthorization supported?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement of the disputed compound?

### **Findings**

1. Memorial is seeking reimbursement for a compound dispensed on July 26, 2017. ACE American Insurance Company denied the disputed compound based on lack of preauthorization. Preauthorization is only required for:
  - drugs identified with a status of “N” in the current edition of the ODG Appendix A;
  - 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.<sup>1</sup>

The compound in question does not include a drug identified with a status of “N” in the current edition of the ODG, Appendix A. The insurance carrier failed to raise any other arguments to support its denial based on preauthorization. Therefore, the division concludes that the compound in question did not require preauthorization and the insurance carrier’s denial of payment for this reason is not supported.

2. Because the insurance carrier’s denial reason is not supported, the compound in question is eligible for reimbursement in accordance with applicable rules and laws.

Memorial included inactive ingredients Ethoxy Diglycol and Versapro Cream, with a compounding fee in its request for medical fee dispute. The division finds no evidence that these ingredients and fees were submitted to the insurance carrier for reimbursement. Therefore, the division cannot recommend reimbursement for these charges.

The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately.<sup>2</sup> Each ingredient is listed below with its reimbursement amount.<sup>3</sup>

<b>Drug</b>	<b>NDC</b>	<b>Generic(G) /Brand(B)</b>	<b>Price /Unit</b>	<b>Units Billed</b>	<b>AWP Formula</b>	<b>Billed Amt</b>	<b>Lesser of AWP and Billed</b>
Baclofen	38779038809	G	\$35.63	5.4	\$240.50	\$190.78	\$190.78
Amantadine	38779041105	G	\$24.23	3	\$90.84	\$72.69	\$72.69
Gabapentin	38779246109	G	\$59.85	3.6	\$269.33	\$204.66	\$204.66
Bupivacaine	38779052405	G	\$45.60	1.2	\$68.40	\$54.72	\$54.72
Amitriptyline	38779018904	G	\$18.24	1.8	\$41.04	\$32.83	\$32.83
						<b>Total</b>	<b>\$555.68</b>

The total allowable reimbursement for the compound in dispute is \$555.68. 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 \$555.68.

<sup>1</sup> 28 Texas Administrative Code §134.530(b)(2)

<sup>2</sup> 28 Texas Administrative Code §134.502(d)(2)

<sup>3</sup> 28 Texas Administrative Code §134.503(c)

**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 \$555.68, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

_____	_____ Laurie Garnes _____	_____ August 23, 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, 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.**