



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

Hartford Casualty Insurance Company

MFDR Tracking Number

M4-18-3729-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

June 4, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The above claimant received medication as prescribed by referral provider ... Memorial Compounding is an approved provider and should be reimbursed accordingly. The referral provider has been treating the patient for the injury sustained at work."

Amount in Dispute: \$566.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "TX requires prescribers to submit requests through UR and not the pharmacy."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 28, 2017	Pharmaceutical Compound	\$566.53	\$566.53

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 §134.502 sets out the procedures for pharmaceutical benefits.
- 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
- 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to certified networks.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 71 – Prescriber is not covered

- 197 – Preauthorization/authorization/notification absent.

Issues

1. Is Hartford Casualty Insurance Company (Hartford)’s denial of payment based on a non-covered prescriber supported?
2. Is Hartford’s denial of payment based on lack of preauthorization supported?
3. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the compound in question?

Findings

1. Memorial is seeking reimbursement of a compound dispensed on September 28, 2017. Hartford denied the disputed compound, in part, with claim adjustment reason code 71, which indicates that the prescriber is not covered.

Review of the submitted documentation failed to support that neither Memorial nor the listed prescriber is not a covered provider. For this reason, the division finds that this denial reason is not supported.

2. Hartford also 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.¹

The compound in question does not include a drug identified with a status of “N” in the current edition of the ODG, Appendix A. Hartford failed to raise any other arguments to support its denial based on preauthorization. Therefore, the Texas Department of Insurance, Division of Workers’ Compensation (DWC) concludes that the compound in question did not require preauthorization and Hartford’s denial of payment for this reason is not supported.

3. Because Hartford failed to support its denial of reimbursement, Memorial is entitled to reimbursement in accordance with applicable rules and laws.

The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately.² Each ingredient is listed below with its reimbursement amount.³ 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	\$43.80	\$35.04	\$35.04
Flurbiprofen	38779036209	G	\$36.58	4.8	\$219.48	\$175.58	\$175.58
Tramadol	38779237409	G	\$36.30	6	\$272.25	\$217.80	\$217.80
Cyclobenzaprine	38779039509	G	\$46.33	1.8	\$104.25	\$83.39	\$83.39
Bupivacaine	38779052405	G	\$45.60	1.2	\$68.40	\$54.72	\$54.72
						Total	\$566.53

The total reimbursement is therefore \$566.53. 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 \$566.53.

¹ 28 Texas Administrative Code §134.530(b)(2)
² 28 Texas Administrative Code §134.502(d)(2)
³ 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 \$566.53, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	_____ Laurie Garnes _____	_____ September 28, 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.