



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

New Hampshire Insurance Co

MFDR Tracking Number

M4-18-4294-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

July 13, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I have attached the EOB's as well as the documentation to prove that Memorial Compounding Pharmacy has met the requirements to receive reimbursement."

Amount in Dispute: \$566.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon reconsideration, the Carrier has paid \$355.91 plus interest in full payment and will issue payment and EOBs to Requestor."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 11, 2017	Meloxicam, Flurbiprofen, Tramadol, Cyclobenzaprine, Bupivacaine	\$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 §134.530 sets out the requirements for prior authorization for pharmacy services.
- 28 Texas Administrative Code §134.503 sets out the reimbursement guidelines for pharmacy services.
- 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

1. The health care provider is requesting reimbursement of compound pharmacy medication dispensed on October 11, 2017. The insurance carrier denied the service as lacking preauthorization.

28 TAC 134.530 (b) (1) B) (D) states preauthorization is required for drugs identified with a status of 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 *ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary* 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 applicable Appendix A referenced above found none of the drugs are listed as a “N” drug nor was evidence of a review by a utilization review organization that found the medication to be investigation or experimental. The insurance carrier’s denial is not supported. The service in dispute will be reviewed per applicable fee guideline.

2. 28 TAC 134.503 (c) (1) (A) (B) states the insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs 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.
 - Generic drugs: $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;
 - Brand name drugs: $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.09) + \4.00 dispensing fee per prescription = reimbursement amount;

Calculation of the fee based on the above is found below.

Medication	NDC	Units	AWP	MAR	Billed amount
Meloxicam	38779274601	0.18	\$194.67	$\$194.67 \times 0.18 \times 1.25 = \43.80	\$35.04
Flurbiprofen	38779036209	4.8	\$36.58	$\$36.58 \times 4.8 \times 1.25 = \219.48	\$175.58
Tramadol HCL	38779237409	6	\$36.30	$\$36.30 \times 6 \times 1.25 = \272.25	\$217.80
Cyclobenzaprine	38779039509	1.8	\$46.33	$\$46.33 \times 1.8 \times 1.25 = \104.24	\$83.39
Bupivacaine HCL	38779052405	1.2	\$45.60	$\$45.60 \times 1.2 \times 1.25 = \68.40	\$54.72
				Total	\$708.17
					\$566.53

3. Per the stated rule above, the lesser amount is the billed amount of \$566.53. This amount is recommended.

Conclusion

For the reasons stated above, DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$566.53.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), DWC has determined the requestor is entitled to additional reimbursement for the disputed services. DWC hereby ORDERS the respondent to remit to the requestor \$566.53, plus applicable accrued interest per 28 TAC §134.130 due within 30 days of receipt of this order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

December 31, 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.