



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

M4-18-5220-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

August 27, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The above claimant received medication and the carrier still has not acknowledged receipt of service. Reimbursement should be made to the provider if the claim has been submitted within the 95th day after the date on which the health care service was rendered."

Amount in Dispute: \$583.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The original bills submitted by Memorial Compound for the four medications were received by the Carrier on 6/19/18 and processed by the Carrier's Bill Review Company on 6/27/18. An Explanation of Benefit (EOB) were sent to the provider on 6/27/18 denying payment due to an absence of precertification/authorization."

Response Submitted by: Law Office of Marc A Notzon PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 26, 2018	Pharmacy Services	\$583.89	\$583.89

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 §134.540 sets out the closed formulary requirements for claims subject to certified networks.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 197 – Payment denied/reduced for absence of precertification/authorization

Issues

1. Is American Zurich Insurance Co's reason for denial of payment supported?
2. Did American Zurich Insurance Co raise a new defense pursuant to 28 Texas Administrative Code §133.307?
3. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the compound in question?

Findings

1. Memorial is seeking reimbursement of \$583.89 for drug(s) dispensed on March 26, 2018. American Zurich Insurance Co denied the disputed compound with claim adjustment reason code 197 – “Payment denied/reduced for absence of precertification/authorization.”

28 Texas Administrative Code §134.540(b) states that preauthorization is **only** required for:

- 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;
- 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
- 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 division finds that the compound in question does not include a drug identified with a status of “N” in the current edition of the ODG, *Appendix A*. American Zurich Insurance Co failed to articulate any arguments to support its denial for preauthorization. Therefore, the division concludes that the compound in question did not require preauthorization and American Zurich Insurance Co's denial of payment for this reason is not supported. Therefore, the disputed compound will be reviewed for reimbursement.

2. In its position statement, Law Office of Marc A Notzon PC argued on behalf of American Zurich Insurance Co, “The Carrier filed a PLN-11 disputing the diagnosis of chondromalacia patella and synovitis on 4/24/18.”

28 Texas Administrative Code §133.307(d)(2)(F) states, in relevant part, “The response shall address 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. Any new denial reasons or defenses raised shall not be considered in the review.”

Review of the submitted documentation finds that [Insurance Carrier] failed to present a extent of injury denial to Memorial in accordance with 28 Texas Administrative Code §133.240 prior to the date the request for medical fee dispute resolution (MFDR) was filed. The division concludes that this defense presented in Law Office of Marc A Notzon PC's position statement shall not be considered for review because this assertion constitutes a new defense pursuant to 28 Texas Administrative Code §133.307(d)(2)(F).

3. 28 Texas Administrative Code §134.503 applies to the compounds in dispute and states, in pertinent part:
 - (c) 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 \text{ per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;
 - (B) Brand name drugs: $((AWP \text{ per unit}) \times (\text{number of units}) \times 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; or

- (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
- (A) health care provider; or
 - (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately as required by 28 Texas Administrative Code §134.502(d)(2). Each ingredient is listed below with its corresponding reimbursement amount as applicable.

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Flurbiprofen	38779036209	G	\$36.58	6	\$274.35	\$219.48	\$219.48
Meloxicam	38779274601	G	\$194.6 7	0.18	\$43.80	\$35.04	\$35.04
Mefenamic Acid	38779066906	G	\$123.6 0	1.8	\$278.10	\$222.48	\$222.48
Baclofen	38779038809	G	\$35.63	3	\$133.61	\$106.89	\$106.89
						Total	\$583.89

The total reimbursement is therefore \$583.89. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$583.89.

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 \$583.89, 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

Date

11/16/2018

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.