TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Memorial Compounding Pharmacy

**Respondent Name**
Westrock MWV LLC

**MFDR Tracking Number**
M4-16-2679-01

**Carrier's Austin Representative**
Box Number 55

**MFDR Date Received**
May 5, 2016

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The attached bill was denied by the carrier. Reconsideration was submitted but denied/or never processed. We are now requesting Medical Fee Dispute Resolution."

**Amount in Dispute:** $489.96

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The Carrier maintains the position it provided on the EOBs as support for allowing no reimbursement for the billed prescriptions."

**Response Submitted by:** Christopher Ameel, PLLC, P.O. Box 5624, Austin, TX 78763

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| July 14, 2015 | Baclofen, Amantadine, Gabapentin, Amitriptyline, Bupivacaine | $489.96 | $0.00 |

## *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 §134.503 sets out the reimbursement guidelines for pharmaceutical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 91 – Dispensing Fee Adjustment
   - 791 – This item is reimbursed as a brand-name prescribed drug
   - D20 – Previously denied by adjuster with PBM
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline

**Issues**

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

**Findings**

1. The insurance carrier denied the disputed service with the following codes:
   - 91 – Dispensing Fee Adjustment
   - 791 – This item is reimbursed as a brand-name prescribed drug
   - D20 – Previously denied by adjuster with PBM
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline

   The EOBS indicate that no payment was allowed for the services in dispute. The carrier fails to explain or demonstrate how reason codes 91, 791, 790 and P12 lead to non-payment. Additionally, the carrier failed to explain or demonstrate what "previously denied by the adjuster with PBM" meant, no did the carrier provide an explanation or evidence of what that "previous denial" was. Not only did the carrier fail to sufficiently explain how it concluded that no payment was due during the medical billing process, it also failed to provide an explanation or documentation during medical fee dispute resolution. In its response to MFDR, the carrier simply states that it "maintains the position it provided on the EOB." The division concludes that the carrier has not supported its denial of the services in dispute. These services will therefore be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code §134.503 (c) states,

   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 per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

   (B) Brand name drugs: ((AWP per unit) x (number of units) x 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;

   Initial review of the medical bills found that the "unit" amount for each ingredient did not clearly indicate what that "unit" of measure was. This information is needed in order to calculate a fee pursuant to §134.503. For example, if the unit of measure is grams, the allowable for that ingredient would be different than if the unit of measure is micrograms, liters, a bottle…etc. The division requested additional information under §133.307(f)(1); however the provider failed to clarify or provide additional information or documentation to clarify what the unit of measure was when indicated in box 23 of the DWC066 form. As a result, the division is unable to calculate the fee.

   The division concludes that the requestor failed to support its request for reimbursement. For that reason, payment cannot be recommended.

**Conclusion**

The Division's findings in this medical fee dispute relied upon the information, documentation, and the defenses that were appropriately and timely raised during the billing process and at medical fee dispute. Even though all evidence was not discussed, it was considered.

The Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

| | | |
|---|---|---|
| | | August 10, 2016 |
| 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 28 Texas Administrative Code §133.307, 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 with the Division. **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**.