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
Accident Fund Insurance Co of America

MFDR Tracking Number
M4-18-2881-01

Carrier's Austin Representative
Box Number 6

MFDR Date Received
April 13, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the reconsideration based on fee schedule. The dispute pharmacy services are in regard Administrative Code 134.503 ©…"

Amount in Dispute: $702.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Accident Fund has elected to reprocess the bill for the disputed date of service."

Response Submitted by: Stone Loughlin & Swanson LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 14, 2017	Pharmacy Services - Compounds	$702.68	$702.68

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 §134.503 sets out the fee guidelines for pharmaceutical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 309 – The charge for this procedure exceeds the fee schedule allowance
   - P12 – Workers compensation jurisdictional fee schedule adjustment

Issues

1. Is the insurance carrier's reason for denial of payment supported?

Findings

1. The requestor is seeking reimbursement of $702.68 for a compound dispensed November 14, 2017. The insurance carrier denied the disputed compound with claim adjustment reason code P12 – "Workers compensation jurisdictional fee schedule adjustment" and 309 – "The charge for this procedure exceeds the fee schedule allowance."

   For the dates of service in dispute the applicable rule is 28 TAC §134.503 which 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 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; or

Ingredient	NDC	Price/ Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Baclofen	38779038809	$35.63	5.4	$240.50	$190.78	$190.78
Amantadine	38779041105	$24.23	3	$90.84	$72.69	$72.69
Gabapentin	38779246109	$59.85	3.6	$269.33	$204.66	$204.66
Bupivacaine	38779052405	$45.60	1.2	$68.40	$54.72	$54.72
Amitriptyline	38779018904	$18.24	1.8	$41.04	$32.83	$32.83
Ethoxy Diglycol	38779190301	$0.34	4.2	$1.80	$1.44	$1.44
Versapro Cream	38779252903	$3.20	40.8	$142.31	$130.56	$130.56
Compounding Fee	NA	$15.00	1	N/A	$15.00	$15.00
					$702.68	$702.68

The total reimbursement is $702.68. 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 $702.68."

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 $702.68, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		October 3, 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.