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
XL Specialty Insurance Co

MFDR Tracking Number
M4-18-3646-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 29, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial Compounding has provided service and met all requirements to received reimbursement."

Amount in Dispute: $583.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Gallagher Bassett Services, Inc. has paid the amount due plus interest on June 8, 2018."

Response Submitted by: Ricky D. Green PLLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 29, 2017	Compound Pharmacy	$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 §134.503 sets out the fee guideline for pharmacy services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization/notification absent

Issues

1. Is the respondent's position supported?
2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of $583.89 for date of service November 29, 2017. The respondent states in their position, "Gallagher Bassett Services, Inc. has paid the amount due plus interest on June 8, 2018."

   Review of the submitted information to date found insufficient evidence to support a payment or denial was made on the date of service in dispute. The services in dispute will be calculated per applicable fee guidelines.

2. 28 TAC 134.503 (c) (1) states in pertinent parts,

   > 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;

   The fee calculation based on the above is shown below:

Drug	NDC	Price / Gram	Grams Billed	AWP Formula	Billed	Lesser
Flurbiprofen	38779036209	$36.58	6	$274.35	$219.48	$219.48
Meloxicam	38779274601	$194.67	0.18	$43.80	$35.04	$35.04
Mefenamic Acid	38779066906	$123.60	1.8	$278.10	$222.48	$222.48
Baclofen	38779038809	$35.63	3	$133.61	$106.89	$106.89
					Total	$583.89

The total allowable amount is $583.89. 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 $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

		October 26, 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.