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
M4-18-4137-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 28, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We received the explanation of benefits but there was no reason for reduction or denial."

Amount in Dispute: $702.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The medical necessity dispute is unresolved."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 25, 2017	Compounded pharmacy	$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 reimbursement guidelines for pharmacy services.
3. 28 Texas Administrative Code §134.530 sets out requirements for pharmacy prior authorization.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing errors which is needed for adjudication

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

The respondent raised medical necessity in their position statement. 28 TAC §133.307 (d)(2)(F) limits DWC MFDR to consider 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.

Review of the submitted explanation of benefits found only a denial based on lack of information that met the requirements of above.

The adverse determinations submitted from the respondent were for dates of service in 2018 not the date of service in dispute. This information will not be considered.

1. The requestor is seeking reimbursement of pharmacy services rendered on October 25, 2017. The insurance carrier denied disputed services based of lack of information.

   No further explanation was given at reconsideration. The services in dispute will be reviewed per applicable fee guideline shown below.

2. 28 TAC 134.503 (c) states the reimbursement for prescription drugs is 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 or the providers billed amount:

   - Generic drugs: ((AWP per unit) x (number of units) x 1.25)
   - Brand name drugs: ((AWP per unit) x (number of units) x 1.09)
   - For compounds a single fee of $15.00 is added

   The calculation of the dispensed medication based on the above is as follows

Medication	NDC	Units	AWP	MAR	Billed amount
Baclofen	38779038809	5.4	$35.63	$35.63 x 1.25 x 5.4 = $240.50	$190.78
Amantadine	38779041105	3	$24.225	$24.225 x 1.25 x 3 = $90.84	$72.69
Gabapentin	38779246109	3.6	$59.85	$59.85 x 1.25 x 3.6 = $269.33	$204.66
Bupivacaine	38779052405	1.2	$45.60	$45.60 x 1.25 x 1.2 = $68.40	$54.72
Amitriptyline	38779018904	1.8	$18.24	$18.24 x 1.25 x 1.8 = $41.04	$32.83
Ethoxy Diglycol	38779190301	4.2	$.342	$0.342 x 1.25 x 4.2 = $1.80	$1.44
Versapro Cream	38779252903	40.8	$3.20	$3.20 x 1.09 x 40.8 = $142.31	$130.56
Compounding fee	n/a	1	n/a	$15.00	$15.00
			Total	$869.22	$702.68

3. The fee schedule amount is $702.68. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established payment is due. As a result, the amount ordered is $702.68.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $702.68, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

		December 20, 2019
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 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.