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
Tx Municipal League Intergovernmental Risk Pool

MFDR Tracking Number
M4-18-4600-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 31, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the original bill as well and the reconsideration based on lack of preauthorization."

Amount in Dispute: $566.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…Memorial does not acknowledge that the prescribing doctor failed to respond to a request for Letter of Medical Necessity. The attached determination from Dr. Pennington supports the legitimacy of the request. No one has supplied the requested information documenting this prescription is medically necessary."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 14, 2017	Pharmacy Services - Compounds	$566.53	$566.53

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. 28 Texas Administrative Code §134.530 sets out prior authorization requirement for pharmacy services.
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 error(s) which is needed for adjudication

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. Additional Payment made on Appeal/Reconsideration DENIED PER PEER REVIEW

Issues

1. Is the respondent's position supported?
2. Is the requestor entitled to reimbursement for the compound in question?

Findings

1. The respondent states in their position, "…Later administrative review from Dr. Pennington (attached) confirmed the legitimate question of the medical necessity of some of these drugs…" Review of the submitted information found one page of a document titled "Peer Review" dated December 12, 2017. This page detailed the medical information review and summary of events. No further information was provided.

   Further review found the submitted documentation did not include a request for a letter of medical necessity as stated in the respondent's position or "administrative review from Dr. Pennington."

   As insufficient evidence was found to support the respondents' position, the review will be based on applicable fee guideline.

2. The applicable fee is found in 28 TAC §134.503 (c) 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 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

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt
Meloxicam	38779274601	G	$194.67	0.18	$43.80	$35.04
Flurbiprofen	38779036209	G	$36.58	4.8	$219.48	$175.58
Tramadol	38779237409	G	$36.30	6	$272.25	$217.80
Cyclobenzaprine	38779039509	G	$46.33	1.8	$104.25	$83.39
Bupivacaine	38779052405	G	$45.60	1.2	$68.40	$54.72
					Total	$566.53

The total reimbursement is $566.53. This amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been discussed, it was considered.

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 $566.53.

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 $566.53, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		July 18, 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 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.