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
New Hampshire Insurance Co

MFDR Tracking Number
M4-18-5122-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 22, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the reconsideration based on NDC # invalid."

Amount in Dispute: $645.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The extent of injury/relatedness dispute is unresolved."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 8, 2017	Pharmacy Services – Compound Cyclobenzaprine 10 mg tablets	$645.94	$596.56

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:
   - 252 – An attachment/other documentation is required to adjudicate this claim/service

Issues

1. Did the respondent present a new defense?
2. Is the requestor entitled to reimbursement for the compound in question?

Findings

1. The insurance carrier states in their position statement, "The extent of injury/relatedness dispute is unresolved." 28 TAC 133.307 (d)(2)(F) states in pertinent part,

   > The response shall address 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. Any new denial reasons or defenses raised shall not be considered in the review.

   Review of the submitted documentation found insufficient evidence to support the insurance carrier's explanation of benefits included a denial for extent or relatedness. Based on the above, this defense will not be considered in this review.

2. 28 TAC §134.503 applies to the compounds in dispute 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

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
Cyclobenzaprine	68162054150	$1.09	30	$40.88	$90.26	$40.88
					Total	$596.56

The total reimbursement is $596.56. 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 $596.56.

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 $596.56, plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this order.

Authorized Signature

____________________________	____________________________	December 14, 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.