



# 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**

Texas Mutual Insurance Co

**MFDR Tracking Number**

M4-19-0039-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

September 04, 2018

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The above claimant received medication and the carrier still has not acknowledged receipt of service. The original bill was submitted to carrier on **01/03/18 via certified mail.**"

**Amount in Dispute:** \$555.68

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The following is the carrier's statement with respect to this dispute of 12/27/17. The requestor listed five different medications in powder form on its bill."

**Response Submitted by:** Texas Mutual Insurance Company

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 27, 2017	Pharmacy Services	\$555.68	\$555.68

### 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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
- 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - P12 – Workers' compensation jurisdiction fee schedule adjustment
  - 872 – Rule 134.502 requires compound drugs be billed by listing each drug included and calculating the charge for each drug separately

**Issues**

1. Is the carrier’s reason for denial of payment supported?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the compound in question?

**Findings**

1. The requestor is seeking reimbursement of \$555.68 for drug(s) dispensed on December 27, 2017. The carrier denied the disputed compound with claim adjustment reason code P12 – Workers’ compensation jurisdictional fee schedule adjustment and 872 - charge for each drug separately.

28 Texas Administrative Code §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
  - (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
    - (A) health care provider; or
    - (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

The drug(s) in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately as required by 28 Texas Administrative Code §134.502(d)(2). Each ingredient is listed below with its corresponding reimbursement amount as applicable.

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Baclofen	38779038809	G	\$35.63	5.4	\$240.50	\$190.78	\$190.78
Amantadine HCL	38779041105	G	\$24.23	3	\$90.84	\$72.69	\$72.69
Gabapentin USP	38779246109	G	\$59.85	3.6	\$269.33	\$204.66	\$204.66
Bupivacaine HCL	38779052405	G	\$45.60	1.2	\$68.40	\$54.72	\$54.72
Amitriptyline HCL	38779018904	G	\$18.24	1.8	\$41.04	\$32.83	\$32.83
						<b>Total</b>	<b>\$555.68</b>

2. The total reimbursement is therefore \$555.68. This amount is recommended.

**Conclusion**

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$555.68.

**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 \$555.68, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

_____	_____	<u>11/9/2018</u>
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.**