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
Indemnity Insurance Company of North America

MFDR Tracking Number
M4-19-0477-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
September 27, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027."

Amount in Dispute: $566.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has submitted the medical bill in dispute for review, and payment is forthcoming. The Carrier will forward a copy of the payment information once the payment is processed."

Response Submitted by: Downs-Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 28, 2018	Compound Medication	$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. The insurance carrier denied payment for the compound in question based on preauthorization.

Issues

Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drug in question?

Findings

Memorial is seeking reimbursement for a compound dispensed on April 28, 2018. In its position statement on behalf of Indemnity Insurance Company of North America, Downs-Stanford, P.C. did not maintain its denial of payment for the compound in question. To date, the insurance carrier did not present evidence that reimbursement was provided to Memorial.

Rule 28 Texas Administrative Code §134.503 applies to the reimbursement on compounds. Compounds are reimbursed by calculating the total allowable amount for each drug listed on the bill separately. [1] The listing of drugs included in the compound are found on the medical bill.[2]

The calculation of the total allowable amount is as follows:

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

The total reimbursement is therefore $566.53. 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 $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

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	April 1, 2019 Date

[1] 28 Texas Administrative Code §134.503(c)

[2] 28 Texas Administrative Code §134.502(d)(2)

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.