



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 Company

MFDR Tracking Number

M4-19-0966-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

October 19, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It looks like the carrier processed the claim but never issued a payment to our facility."

Amount in Dispute: \$555.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester listed four different medications in powder form on its bill. Compound powders typically require an agent such as ethoxy diglycol to deliver the compound medication to the skin surface for absorption. Texas Mutual declined to issue payment absent billing for such an agent as required by Rule 134.502."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 14, 2018	Compound Medication	\$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 guidelines for billing pharmaceutical services.
- 28 Texas Administrative Code §134.503 sets out the fee schedule for pharmaceutical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - CAC-P12 – Workers' compensation jurisdictional 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.
- CAC-18 – Exact duplicate claim/service
- 224 – Duplicate charge.

Issues

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

Findings

The compound in dispute was billed by listing each **drug** included in the compound and calculating the charge for each drug separately.¹ Each ingredient is listed below with its reimbursement amount.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
Baclofen	38779038809	G	\$35.63	5.4	\$240.50	\$190.78	\$190.78
Amantadine	38779041105	G	\$24.23	3	\$90.84	\$72.69	\$72.69
Gabapentin	38779246109	G	\$59.85	3.6	\$269.33	\$204.66	\$204.66
Bupivacaine	38779052405	G	\$45.60	1.2	\$68.40	\$54.72	\$54.72
Amitriptyline	38779018904	G	\$18.24	1.8	\$41.04	\$32.83	\$32.83
						Total	\$555.68

The total reimbursement is therefore \$555.68. 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 \$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

Signature

Laurie Garnes

Medical Fee Dispute Resolution Officer

August 16, 2019

Date

¹ 28 Texas Administrative Code §134.502(d)(2)
² 28 Texas Administrative Code §134.503(c)

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.