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
AIG Assurance Company

MFDR Tracking Number
M4-19-1231-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 2, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These medications do not require preauthorization therefore do not need a retrospective review."

Amount in Dispute: $555.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the Carrier's position that the 3/29/2018 prescriptions are not owed per the 4/17/2018 eob. The bill was reviewed on 4/17/2018 and denied because payment reduced or denied based on workers' compensation regulations or payment policies."

Response Submitted by: AIG Claims, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 29, 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

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:
   - HE70 – Product/Service Not Covered
   - P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.

Issues

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

Findings

Memorial is seeking reimbursement for a compound dispensed on March 29, 2018. Compound drugs are covered by Title 28 of the Texas Administrative Code, Part 2, Chapter 134, Subchapter F.

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	July 9, 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.