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
Granite State Insurance Company

MFDR Tracking Number
M4-19-1252-01

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: $851.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier is still in the process of reviewing the request."

Response Submitted by: AIG

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 29, 2018	Compound Medication	$583.89	$583.89
March 29, 2018	Lenzapatch 4%-1%	$267.50	$232.90
	Total	$851.39	$816.79

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 (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.502 sets out the procedures for billing pharmaceutical services.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 1 – Product/Service Not Covered

Issues

Is Memorial Compounding Pharmacy (Memorial) entitled to additional reimbursement?

Findings

Memorial is seeking reimbursement for drugs dispensed on March 29, 2018. The insurance carrier denied payment stating, "Product/Service Not Covered."

In its position statement, AIG stated, "We will supplement this response once a final determination is made." To date, no supplemental response has been received. For this reason, the DWC will review this dispute with the information available.

Pharmaceutical services, including those considered in this dispute, are covered under 28 TAC, 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
Flurbiprofen	38779036209	G	$36.58	6	$274.35	$219.48	$219.48
Meloxicam	38779274601	G	$194.67	0.18	$43.80	$35.04	$35.04
Mefenamic Acid	38779066906	G	$123.60	1.8	$278.10	$222.48	$222.48
Baclofen	38779038809	G	$35.63	3	$133.61	$106.89	$106.89
						Total	$583.89

The reimbursement for Lenzapatch is calculated as follows[3]:

- (42.0 x 5 x 1.25) + $4.00 = $232.90

The total allowable for the drugs in question is $816.79. This amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $816.79.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services.
The DWC hereby ORDERS the respondent to remit to the requestor $816.79, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	October 11, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 Texas Administrative Code §134.502(d)(2)
[2] 28 Texas Administrative Code §134.503(c)
[3] 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.