



# 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**

Liberty Insurance Corp

**MFDR Tracking Number**

M4-19-1302-01

**Carrier's Austin Representative**

Box Number 1

**MFDR Date Received**

November 5, 2018

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The carrier denied the reconsideration based on partial payment. It looks like the carrier processed and paid on partial of the total bill."

**Amount in Dispute:** \$522.85

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The 3/29/18 compounded medication was not denied as requiring preauthorization, as investigational or as experimental. It was denied as not medically necessary following completion of a retrospective medical necessity review."

**Response Submitted by:** Liberty Mutual Insurance

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 29, 2018	Pharmacy Services - Compounds	\$522.85	\$522.85

### 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. Neither party submitted an explanation of benefits for the date of service or medications listed on the DWC060.

**Issues**

1. Did the respondent present a new defense?
2. Is the requestor entitled to reimbursement for the compound in question?

**Findings**

1. The insurance carrier states in their position statement, "...medication deemed not medically necessary." 28 TAC 133.307 (d)(2)(F) states in pertinent part,

The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

Review of the submitted documentation found insufficient evidence to support the insurance carrier denied the services with a "medical necessity" denial on an explanation of benefits. Based on the above, this defense will not be considered in this review.

2. 28 TAC §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

Ingredient	NDC	Price/Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Baclofen	38779038809	\$35.63	5.4	\$240.50	\$190.78	\$190.78
Amantadine	38779041105	\$24.23	3	\$90.84	\$72.69	\$72.69
Gabapentin	38779246109	\$59.85	3.6	\$269.33	\$204.66	\$204.66
Bupivacaine	38779052405	\$45.60	1.2	\$68.40	\$54.72	\$54.72
Total						\$522.85

The total reimbursement is \$522.85. This amount is recommended.

**Conclusion**

For the reasons stated above, DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$522.85.

**ORDER**

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), DWC has determined the requestor is entitled to additional reimbursement for the disputed services. DWC hereby ORDERS the respondent to remit to the requestor \$522.85, plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

November 28, 2018  
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.**