



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 Mutual Fire Insurance Co

MFDR Tracking Number

M4-19-1303-01

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 claim not processed."

Amount in Dispute: \$798.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The 3/14/18 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 14, 2018	Pharmacy Services - Compounds	\$798.06	\$798.06

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 §133.240 set s out requirements of explanation of benefits.
 3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
- Neither party submitted an explanation of benefits with the request for medical fee dispute.

Issues

1. Was an explanation of benefits found in submitted documentation?
2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking \$798.06 for pharmacy services rendered on March 14, 2018. No explanation of benefits was submitted by either party.

28 TAC 133.240 (e) states in pertinent part,

The insurance carrier shall send the explanation of benefits in accordance with the elements required by §133.500 and §133.501 of this title (relating to Electronic Formats for Electronic Medical Bill Processing and Electronic Medical Bill Processing, respectively) if the insurance carrier submits the explanation of benefits in the form of an electronic remittance. The insurance carrier shall send an explanation of benefits in accordance with subsection (f) of this section if the insurance carrier submits the explanation of benefits in paper form

DWC found insufficient evidence to support the insurance carrier met the requirements of the above. The services in dispute will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code §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 \text{ per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs: $((AWP \text{ per unit}) \times (\text{number of units}) \times 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)
Flurbiprofen	38779036209	\$36.58	6	\$274.35	\$219.48	\$219.48
Meloxicam	38779274601	\$194.67	0.18	\$43.80	\$35.04	\$35.04
Mefenamic acid	38779066906	\$123.60	1.8	\$278.10	\$222.48	\$222.48
Baclofen	38779038809	\$35.63	3	\$133.61	\$106.89	\$106.89
Bupivacaine	38779052405	\$45.60	1.2	\$68.40	\$54.72	\$54.72
Ethoxy Diglycol	38779190301	\$0.34	3	\$1.28	\$1.03	\$1.03
Versapro Cream	38779252903	\$3.20	44.82	\$156.33	\$143.42	\$143.42
Compounding Fee		\$15.00	1	n/a	\$15.00	\$15.00
						\$798.06

The total reimbursement is \$798.06. 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 \$798.06.

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 \$798.06, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	_____	November 20, 2018
Signature	Medical Fee Dispute Resolution Officer	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.