TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Memorial Compounding Pharmacy

**Respondent Name**
Ole Republic Insurance Co

**MFDR Tracking Number**
M4-19-1624-01

**Carrier's Austin Representative**
Box Number 44

**MFDR Date Received**
November 20, 2018

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The Texas labor Code Section 408.027 (b) requires that the carrier must pay, reduce, deny or determine to audit the health provider's claim no later than the 45th day after the date of receipt by the carrier. Memorial did not receive any correspondence as per rule…"

**Amount in Dispute:** $702.68

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** No position statement submitted.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| June 28, 2018 | Pharmacy | $702.68 | $702.68 |

## *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 guidelines for pharmacy reimbursement
3. Neither party submitted an explanation of benefits for the services provided.

**Issues**

1. What rule is applicable to reimbursement?

**Findings**

The Austin carrier representative for Old Republic Insurance Co acknowledged receipt of the copy of this medical fee dispute on November 29, 2018. 28 Texas Administrative Code §133.307 states, in relevant part:

> (d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
> (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

Review of the documentation finds that no response has been received on behalf of the insurance carrier to date. The division concludes that the insurance carrier failed to respond within the timeframe required by §133.307(d)(1). DWC will base its decision on the information available.

1. The requestor seeks reimbursement for pharmacy services rendered July 28, 2018. The insurance carrier provided no evidence of payment or reason for denial. The services will be reviewed per 28 TAC §134.503 (c) which states in pertinent part,

   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

| 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 |
| Ethoxy Diglycol | 38779190301 | G | $0.34 | 4.2 | $1.80 | $1.44 | $1.44 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Versapro Cream | 38779252903 | B | $3.20 | 40.8 | $142.31 | $130.56 | $130.56 |
| Fee | NA | NA | NA | NA | $15.00 | $15.00 | $15.00 |
| | | | | | | Total | $702.68 |

The allowed amount based on the applicable fee guideline is $702.68. 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 $702.68.

***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 $702.68, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | June 21, 2019<br>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**.