



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

Ace American Insurance Co

MFDR Tracking Number

M4-19-1780-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

November 28, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...the carrier cannot change from the original denial."

Amount in Dispute: \$702.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company has determined no further payment is due."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 16, 2018	Compound medication	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
- 28 Texas Administrative Code §134.530 sets out prior authorization requirement for pharmacy services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 242 – Services not provided by network/primary care providers
 - 243- Services not authorized by network/primary care providers

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. Is the requestor entitled to reimbursement for the compound in question?

Findings

1. The requestor is seeking reimbursement of \$702.68 for a compound dispensed May 16, 2018. The carrier denied the disputed compound stating services not provided by network provider.

Review of the submitted documentation found insufficient evidence to support the injured worker was enrolled in a network. This denial submitted on the explanation of benefits is not supported and will not be considered in this review. The disputed service will be reviewed per applicable fee guideline.

2. 28 Texas Administrative Code §134.503 (c) applies to the disputed service 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: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs: $((\text{AWP 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

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 total reimbursement is \$702.68. This amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been discussed, it was considered.

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

September 12, 2019
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.