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
State Farm Fire & Casualty Co

MFDR Tracking Number
M4-19-1799-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
November 28, 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: $970.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has submitted the medical bill in dispute for review, and an additional payment is forthcoming."

Response Submitted by: Downs Stanford P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 12, 2018	Compounded pharmacy and prescribed oral medication	$970.20	$0.00

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 pharmacy services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.

Issues

1. What rule is applicable to the disputed services?

Findings

1. The requestor sought MFDR on November 16, 2018 for services that had not been paid by the carrier. The carrier responded on December 19, 2018 and provided evidence of a payment made in the amount of $931.69 via electronic funds transfer on December 18, 2019.

   The dispute was not withdrawn by the requestor. The services in dispute will be calculated per applicable fee guideline.

   28 TAC §134.503 (c) (1) (A)(B)(C) states in pertinent parts, the reimbursement for prescription drugs is the lesser of 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 or the billed amount.

   Generic drugs: ((AWP per unit) x (number of units) x 1.25), Brand name drugs: ((AWP per unit) x (number of units) x 1.09, and when compounding, a single compounding fee of $15 per prescription shall be added to the calculated total.

   The calculation per the above is as follows:

Medication	NDC	Generic or Brand name	Units	AWP	MAR AWP x 1.25 x units or AWP x 1.09 x units	Billed Amount
Baclofen	38779038809	Generic	5.4	$35.63	$240.50	**$190.78**
Amantadine	38779041105	Generic	3	$24.23	$90.86	**$72.69**
Gabapentin	38779246109	Generic	3.6	$59.85	$269.33	**$204.66**
Bupivacaine	38779052405	Generic	1.2	$45.60	$68.40	**$54.72**
Amitriptyline	38779018904	Generic	1.8	$18.24	$41.04	**$32.83**
Ethoxy Diglycol	38779190301	Generic	4.2	$0.34	$1.79	**$1.44**
Versapro Cream	Versapro cream	Brand	40.8	$3.20	$142.31	**$130.56**
Compounding fee	N/A					**$15.00**
Cyclobenzaprine	65162054150	Generic	30	$1.09	**$40.88**	$90.26
Gabapentin	67877022305	Generic	90	$1.33	**$149.63**	$177.26

The allowed amount is **bolded** above $893.19. The insurance company paid $931.69. No additional payment is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		December 11, 2019
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.