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
K MART CORP

MFDR Tracking Number
M4-19-2347-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
December 21, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "we submitted the original bill and then requested the carrier review bill again and we still did not get a response."

Amount in Dispute: $702.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "payment was issued on 1/4/19 via electronic funds transfer."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
August 31, 2018	Pharmacy Services	$702.68	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 guideline for pharmacy services.
3. The insurance carrier denied payment based on the following claim adjustment codes:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 3 – CHARGE FOR PHARMACEUTICALS EXCEED THE FEES ESTABLISHED BY THE FEE SCHEDULE.
   - 91 – DISPENSING FEE ADJUSTMENT.
   - 1 – A DISPENSING FEE IS NOT APPLICABLE TO THE ALLOWANCE OR PAYMENT OF THE MEDICATION.

Findings

Is additional reimbursement due?

Rule §134.503(c) requires the insurance carrier to reimburse prescription drugs the lesser of: (1) the fee established by formula in the rule based on the average wholesale price (AWP) as reported by nationally recognized pharmaceutical pricing data; or (2) the amount billed.

Reimbursement is calculated as follows:

Ingredient(s)	NDC & Type	Unit Price	Total Units	AWP Formula §134.503(c)(1)	Billed Amount §134.503(c)(2)	Lesser of (c)(1) or (c)(2)
BACLOFEN	38779038809 Generic	$35.63	5.4	($35.63 × 5.4) × 1.25 = $240.50	$190.78	$190.78
AMANTADINE HCL	38779041105 Generic	$24.23	3	($24.23 × 3) × 1.25 = $90.84	$72.69	$72.69
GABAPENTIN	38779246109 Generic	$59.85	3.6	($59.85 × 3.6) × 1.25 = $269.33	$204.66	$204.66
BUPIVACAINE HCL	38779052405 Generic	$45.60	1.2	($45.60 × 1.2) × 1.25 = $68.40	$54.72	$54.72
AMITRIPTYLINE HCL	38779018904 Generic	$18.24	1.8	($18.24 × 1.8) × 1.25 = $41.04	$32.83	$32.83
ETHOXY DIGLYCOL	38779190301 Generic	$0.34	4.2	($0.34 × 4.2) × 1.25 = $1.80	$1.44	$1.44
VERSAPRO	38779252903 *Brand*	$3.20	41	($3.20 × 40.8) × 1.09 = $142.31	$130.56	$130.56
			Total Units: 60		Subtotal:	$687.68
					+ $15 compound fee = **Total**:	$702.68

The total recommended reimbursement for the disputed services is $702.68.

The insurance carrier provided documentation with their response to support payment of $702.68 was issued for these disputed pharmacy services by electronic funds transfer on January 4, 2019. Based on the submitted information no additional payment is due.

Conclusion

The division concludes the requestor has been paid for the disputed services. 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

	Grayson Richardson	March 1, 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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.