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 Insurance Corp

**MFDR Tracking Number**
M4-20-1946-01

**Carrier's Austin Representative**
Box Number 01

**MFDR Date Received**
April 13, 2020

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "I have attached the EOB's as well as the documentation to prove that Memorial Compounding Pharmacy has met the requirements to receive reimbursement."

**Amount in Dispute:** $455.04

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The 01/23/2020 medication was denied as not medically necessary following completion of a retrospective medical necessity review."

**Response Submitted by:** Liberty Mutual

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| January 23, 2020 | Oral medication | $455.04 | $353.25 |

## *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 pharmaceutical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 203 – Peer review determined – payment for treatment has not been recommended due to the lack of medical necessity

**Issues**

1. Is the requestor's position supported?
2. What rule(s) apply to disputed services?

**Findings**

1. The requestor is seeking reimbursement for oral medication dispensed January 23, 2020. The insurance carrier states that a retrospective review was done that found the medication not medically necessary. Review of the submitted documentation found the Medical Peer Review is dated July 22, 2017. The medications Gabapentin, Acetaminophen-Codeine and Celecoxib were reviewed.

   The medications in dispute are Ibuprofen, Omeprazole and Cyclobenzaprine.

   The insurance carrier's adverse determination based on retrospective review is not supported and will not be considered in this review.

2. 28 Texas Administrative Code §134.503 (c) states the insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs 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:
   - Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
   - Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;

| Drug | NDC | Generic(G) /Brand(B) | Price /Unit | Units Billed | AWP Formula | Billed Amt | Lesser of AWP and Billed |
|---|---|---|---|---|---|---|---|
| Ibuprofen | 67877032005 | G | 0.52 | 60 | $0.52 x 1.25 x 60 = $39.00 | $88.42 | $39.00 |
| Omeprazole | 62175011843 | G | $3.37 | 60 | $3.37 x 1.25 x 60 = $252.75 | $259.90 | $252.75 |
| Cyclobenzaprine | 52817033050 | G | $1.64 | 30 | $1.64 x 1.25 x 30 = $61.50 | $106.72 | $61.50 |
| | | | | | | | $353.25 |

The total reimbursement is $353.25. This amount 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 established payment is due. As a result, the amount ordered is $353.25.

## *ORDER*

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $353.25, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

| | | |
|---|---|---|
| | | April 27, 2020 |
| 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**.