



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

Great West Casualty Co

MFDR Tracking Number

M4-18-2880-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

April 13, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim should be processed with the full amount billed as per Administrative Labor Code 134.503."

Amount in Dispute: \$979.69

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of review

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 7, 2017	Pharmacy Services - Compounds	\$979.69	\$905.20

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 §134.502 sets out the procedures for pharmaceutical benefits.
- 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – Workers' compensation jurisdiction fee schedule adjustment
 - W3 – In accordance with TDI-DWC Rule 134.804, this has been identified as a request for reconsideration or appeal

Issues

1. Did the carrier respond to the medical fee dispute?
2. Is the carrier's reason for denial of payment supported?
3. Is the requestor entitled to reimbursement for the compound in question?

Findings

1. The Austin carrier representative for Great West Casualty Co is JT Parker & Associates LLC. JT Parker & Associates LLC acknowledged receipt of the copy of this medical fee dispute on April 20, 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 Great West Casualty Co from JT Parker & Associates LLC to date. The division concludes that Great West Casualty Co failed to respond within the timeframe required by §133.307(d)(1). For that reason the division will base its decision on the information available.

2. The requestor is seeking reimbursement of \$979.69 for a compound dispensed on November 7, 2017. The carrier denied the disputed compound with claim adjustment reason code P12 – Workers' compensation jurisdictional fee schedule adjustment."

28 Texas Administrative Code §134.503 applies to the compounds in dispute 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
- (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
 - (A) health care provider; or
 - (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

The medication and compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately as required by 28 Texas Administrative Code §134.502(d)(2).

Each ingredient found on the submitted DWCO66 is listed below with its corresponding reimbursement amount as applicable.

Ingredient	NDC & Type	Price/ Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Meloxicam	29300012510	\$4.845	30	\$181.69	\$202.85	\$181.69
Tramadol	69543013611	\$0.833	20	\$20.83	\$74.16	\$20.83
Baclofen	38779038809	\$35.63	5.4	\$240.50	\$190.78	\$190.78
Amantadine	38779041105	\$24.23	3	\$90.84	\$72.69	\$72.69
Gabapentin	38779246109	\$59.85	3.6	\$269.33	\$204.66	\$204.66
Bupivacaine	38779052405	\$45.60	1.2	\$68.40	\$54.72	\$54.72
Amitriptyline	38779018904	\$18.24	1.8	\$41.04	\$32.83	\$32.83
Ethoxy Diglycol	38779190301	\$.342	4.2	\$1.80	\$1.44	\$1.44
Versapro Cream	38779252903	\$3.20	40.8	\$163.20	\$130.56	\$130.56
Compounding Fee		\$15.00	1		\$15.00	\$15.00
					Total	\$905.20

3. The total reimbursement is \$905.20. Insufficient evidence was found to support any previous payment therefore, 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 \$905.20.

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 \$905.20, 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

July 24, 2018
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.