



# TEXAS DEPARTMENT OF INSURANCE

## Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Memorial Compounding Pharmacy

**Respondent Name**

Granite State Insurance Company

**MFDR Tracking Number**

M4-18-2940-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

April 16, 2018

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The above claimant received medication as prescribed by referral provider."

**Amount in Dispute:** \$583.89

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "In review of this dispute, the Carrier received the initial DWC-66 on 2/15/18. No payment was issued due to the fact the product/service is not covered."

**Response Submitted by:** AIG

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 28, 2017	Pharmaceutical Compound	\$583.89	\$583.89

#### 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 submitted documentation did not include explanations of benefits for the compound in dispute.

**Issues**

Is the requestor entitled to reimbursement for the disputed compound?

**Findings**

Memorial Compounding Pharmacy (Memorial) is seeking reimbursement for a compound dispensed on November 28, 2017. No explanation of benefits was submitted indicating a denial of the disputed compound. Therefore, the division finds that Memorial is entitled to reimbursement.

The services in question are covered under 28 TAC §134.503. The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately.<sup>1</sup> Each ingredient is listed below with its reimbursement amount.<sup>2</sup> The calculation of the total allowable amount is as follows:

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Flurbiprofen	38779036209	G	\$36.58	6	\$274.35	\$219.48	\$219.48
Meloxicam	38779274601	G	\$194.67	0.18	\$43.80	\$35.04	\$35.04
Mefenamic Acid	38779066906	G	\$123.60	1.8	\$278.10	\$222.48	\$222.48
Baclofen	38779038809	G	\$35.63	3	\$133.61	\$106.89	\$106.89
						Total	\$583.89

The total allowable reimbursement for the compound in dispute is \$583.89. 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 \$583.89.

***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 \$583.89, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Laurie Garnes  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
August 8, 2018  
Date

<sup>1</sup> 28 Texas Administrative Code §134.502(d)(2)

<sup>2</sup> 28 Texas Administrative Code §134.503(c)

### ***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.**