



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

Zurich American Insurance Co

MFDR Tracking Number

M4-18-4139-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

June 28, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The NDC number provided is a valid NDC number and claim should be processed accordingly."

Amount in Dispute: \$726.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has requested the bill be paid and the Carrier understands it is in line for payment through Optum."

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount in Dispute, Amount Due. Row 1: October 25, 2017, Compounded pharmacy, \$726.62, \$711.62

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 reimbursement guidelines for pharmacy services.
3. 28 Texas Administrative Code §134.530 sets out requirements for pharmacy prior authorization.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
• 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication

**Issues**

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

**Findings**

1. The requestor is seeking reimbursement of pharmacy services rendered on October 25, 2017. The insurance carrier denied disputed services based of lack of information. Review of the submitted DWCO66 found each medication listed had a valid NDC number. There was no explanation code as to the zero payment of the medications.

The “Generic NDC” listed for compounding fee was 99999-9999-99. Insufficient evidence was found to support the requestor’s statement that this is a valid code. The denial for this code is upheld. The remaining charges will be reviewed per applicable fee guideline.

2. 28 TAC 134.503 (c) states 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 providers 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)
  - For compounds a single fee of \$15.00 is added

The calculation of the dispensed medication based on the above is as follows

Medication	NDC	Units	AWP	MAR	Billed amount
Meloxicam	38779274601	.18	\$194.67	$\$194.67 \times 1.25 \times .18 = \$43.80$	\$35.04
Flurbiprofen	38779036209	4.9	\$36.58	$\$36.58 \times 1.25 \times 4.9 = \$224.05$	\$175.58
Tramadol	38779237409	6	\$36.30	$\$36.30 \times 1.25 \times 6 = \$272.25$	\$217.80
Cyclobenzaprine	38779039509	1.8	\$46.33	$\$46.33 \times 1.25 \times 1.8 = \$104.24$	\$83.39
Bupivacaine	38779052405	1.2	\$45.60	$\$45.60 \times 1.25 \times 1.2 = \$68.40$	\$54.72
Ethoxy Diglycol	38779190301	3	\$0.342	$\$0.342 \times 1.25 \times 3 = \$1.28$	\$1.03
Versapro Cream	38779252903	45.2	\$3.20	$\$3.20 \times 1.09 \times 45.2 = \$157.66$	\$144.06
				Total	\$711.62

3. The fee schedule amount is \$711.62. 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 \$711.62.

**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/is not entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor \$711.62, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

December 20, 2019  
\_\_\_\_\_  
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.**