



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

Lumbermens Underwriting Alliance

MFDR Tracking Number

M4-16-1066-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

December 21, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached bills have been denied by the carrier stating untimely filing. Memorial Compounding Pharmacy rebuttal stated and should proof of timely filing. Reconsideration has been denied."

Amount in Dispute: \$609.33

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The EOBs raise timely filing of the bills. Under Sec. 408.027(a), health care providers (HCPs) have 95 days from the date of service to submit a medical bill to the insurance carrier."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: December 30, 2014, Prescription Medications (Compound Cream), \$609.33, \$609.33

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 §133.20 sets out medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
4. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
5. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
• 29 – Time Limit for Filing Claim/Bill has Expired

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. What is the total reimbursement for the disputed service?
3. Is the requestor entitled to reimbursement for the disputed service?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 29 – "Time Limit for Filing Claim/Bill has Expired" 28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

Further, Texas Labor Code §408.027(a) states that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states,

Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:

- (1) the date received, if sent by fax, personal delivery or electronic transmission or,
- (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.

Review of the submitted information finds that documentation supports that a bill for the service in question was submitted in accordance with 28 Texas Administrative Code §133.20(b). The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. The total reimbursement for the disputed services is established by the AWP formula pursuant to 28 Texas Administrative Code §134.503(c), which states, in relevant part:

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...

The requestor is seeking reimbursement for a compound, with compounding fee, of the generic drugs Amantadine HCl, NDC 38779041105; Baclofen, NDC 38779038809; Bupivacaine HCl, NDC 38779052405; USP, NDC 38779246109; Ethoxy Diglycol, NDC 38779190301; Amitriptyline HCl, NDC 38779018904; and brand name drug Versapro Cream, NDC 38779252903. The disputed medication was dispensed on December 30, 2014. The reimbursement is calculated as follows:

Date of Service	Prescription Drug	Calculation per §134.503 (c)(1)	§134.503 (c)(2)	Lesser of §134.503 (c)(1) & (2)	Carrier Paid	Balance Due
12/30/14	Amantadine HCl	$(24.22500 \times 3.0 \times 1.25) + \$4.00 = \$94.84$	\$38.46	\$38.46	\$0.00	\$38.46
12/30/14	Baclofen	$(35.63000 \times 5.4 \times 1.25) + \$4.00 = \$244.50$	\$184.68	\$184.68	\$0.00	\$184.68
12/30/14	Bupivacaine HCl	$(45.60000 \times 1.2 \times 1.25) + \$4.00 = \$72.40$	\$48.02	\$48.02	\$0.00	\$48.02
12/30/14	Gabapentin USP	$(59.85000 \times 3.6 \times 1.25) + \$4.00 = \$268.83$	\$188.10	\$188.10	\$0.00	\$188.10
12/30/14	Ethoxy Diglycol	$(0.34200 \times 4.2 \times 1.25) + \$4.00 = \$5.80$	\$1.44	\$1.44	\$0.00	\$1.44
12/30/14	Amitriptyline HCl	$(18.24000 \times 1.8 \times 1.25) + \$4.00 = \$45.04$	\$31.63	\$31.63	\$0.00	\$31.63
12/30/14	Versapro Cream	$(3.20000 \times 40.8 \times 1.09) + \$4.00 = \$146.31$	\$102.00	\$102.00	\$0.00	\$102.00
12/30/14	Compounding Fee	\$15.00	\$15.00	\$15.00	\$0.00	\$15.00

3. The total reimbursement for the disputed service is \$609.33. The insurance carrier paid \$0.00. A reimbursement of \$609.33 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 \$609.33.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$609.33 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

January 29, 2016
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 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 with the Division. **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.