



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

Sentrix Pharmacy and Discount LLC

Respondent Name

Lockheed Martin Corp

MFDR Tracking Number

M4-16-1984-01

Carrier's Austin Representative

Box Number 60

MFDR Date Received

March 14, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The insurance carrier, ESIS West WC Claims, failed to take final action on the claim within the 45-day period set forth in TAC §133.240. Specifically the claim was submitted and received by the provider on 12/15/15 (as verified by the attached proof of delivery) and no action was taken on the claim."

Amount in Dispute: \$2,289.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the Carrier's position that the provider is not entitled to reimbursement as the treatment is not medical necessary."

Response Submitted by: ESIS, P.O. Box 6563 Scranton, PA 18505-6563

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 2, 2015	Pharmacy Services	\$2,289.71	\$2,289.71

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 §133.240 sets out procedures for medical payments and denials.
3. 28 Texas Administrative Code §133.250 sets out procedures for reconsideration for payment of medical bills.
4. 28 Texas Administrative Code §102.4 sets out general rules for non-commission communications.

5. 28 Texas Administrative Code §134.503 sets out the reimbursement guidelines for pharmacy services not subject to a certified network.
6. No explanation of benefits was submitted by either party in this dispute.

Issues

1. Is the requestor's position statement supported?
2. Did the carrier take final action on the bill in compliance with Division rules?
3. Did the requestor comply with Division rules pertaining to reconsideration?
4. What is the applicable rule pertaining to reimbursement?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor states in their position statement, "The Pharmacy attaches the following documentation in support of this Medical Fee Dispute Resolution Request: Copy of bills submitted that includes a copy of the prescription with proof of delivery Second request for payment submitted after expiration of 45 days..." and "The insurance carrier, ESIS West WC Claims, failed to take final action on the claim within the 45-day period set forth in TAC §133.240."

Review of the submitted documentation finds:

- Completed DWC066 for date of service December 2, 2015 with date of billing, December 11, 2015 with Carrier address, P.O. Box 6569, Scanton, PA 18505-6569.
- USPS tracking document shows certified mail document shipped on December 12, 2015 and delivered on December 15, 2015 to Scranton, PA 18505

28 Texas Administrative Code §102.4 (h) states in pertinent part,

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.

The Division finds the requestor's position of timely submission is supported.

2. 28 Texas Administrative Code §133.240(a) states,

An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill.

28 Texas Administrative Code (e) states,

The insurance carrier shall send the explanation of benefits in accordance with the elements required by §133.500 and §133.501 of this title (relating to Electronic Formats for Electronic Medical Bill Processing and Electronic Medical Bill Processing, respectively) if the insurance carrier submits the explanation of benefits in the form of an electronic remittance. The insurance carrier shall send an explanation of benefits in accordance with subsection (f) of this section if the insurance carrier submits the explanation of benefits in paper form. The explanation of benefits shall be sent to:

- (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill;

28 Texas Administrative Code (f) states, “The paper form of an explanation of benefits under subsection (e) of this section ...shall include the following elements:... (9) insurance carrier’s name and address; (12) diagnosis code; (the CPT, HCPCS, NDC, or other applicable product or service code; (17)(G) the adjustment reason code that conforms to the standards described in §133.500...”

The Division finds no documentation was found to support than an explanation of benefits that complies with the requirements of §33.240, the division further concludes that the defenses presented in the carrier’s position statement at medical fee dispute shall not be considered for review because those assertions constitutes new defenses pursuant to 28 Texas Administrative Code §133.307(d)(2)(F). Therefore the services in dispute will be reviewed per applicable rules and fee guidelines.

3. Additionally, 28 Texas Administrative Code §133.250 (a) (c)(1)(2) states,

If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill, the health care provider may request that the insurance carrier reconsider its action. If the health care provider is requesting reconsideration of a bill denied based on an adverse determination, the request for reconsideration constitutes an appeal for the purposes of §19.2011 of this title (relating to Written Procedures for Appeal of Adverse Determinations) and may be submitted orally or in writing.

(c) A health care provider shall not submit a request for reconsideration until:

- (1) the insurance carrier has taken final action on a medical bill; or
- (2) the health care provider has not received an explanation of benefits within 50 days from submitting the medical bill to the insurance carrier..

Review of the submitted documentation finds:

- Request for payment and/or notification sent to carrier on February 1, 2016
- USPC certified mail receipt shows delivered on February 5, 2016

The Division finds sufficient evidence to support a request for payment and/or explanation of benefits was made by the requestor within guidelines of Rule 133.250. For all the reasons stated above, the services in dispute will be reviewed per applicable rules and fee guidelines.

4. The services in dispute is for the medications Ketoprofen 10% Powder per bottle, Amitriptyline 2% Bulk Powder per bottle, Baclofen 4% Powder per bottle, Amantadine 8% bulk powder per bottle, Gabapentin 5% Powder per bottle, Versatile Base Cream per bottle and are therefore subject to the requirements of 28 Texas Administrative Code §134.503(c) which states,

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: $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs: $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.09) + \4.00 dispensing fee per prescription = reimbursement amount;

The maximum allowable reimbursement will be calculated as follows:

Date of Service	Service in Dispute	Quantity	Amount Billed	MAR $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.25)$
December 2, 2015	Ketoprofen Powder per bottle	24	\$250.80	$\$10.45000 \times 24 \times 1.25 + \$4.00 = \$317.50$
December 2, 2015	Amitriptyline bulk	5	\$87.55	$\$18.24000 \times 5 \times 1.25 = \114.00

	Powder per bottle			
December 2, 2015	Baclofen Powder per bottle	10	\$342.04	$\$35.63000 \times 10 \times 1.25 = \445.38
December 2, 2015	Amantadine 8% Powder per bottle	20	\$465.12	$\$24.22500 \times 20 \times 1.25 = \605.63
December 2, 2015	Gabapentin 5% Powder per bottle	12	\$718.20	$\$59.85000 \times 12 \times 1.25 = \897.75
December 2, 2015	Versatile Base Cream per bottle	170	\$426.00	$\$2.50000 \times 170 \times 1.25 = \531.25
		Total	\$2,289.71	\$2,911.51

5. The maximum allowable for the services in dispute based on the submitted NDC code(s) and number of units is \$2,911.51. The requestor is seeking \$2,289.71. 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 \$2,289.71.

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 in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$2,289.71 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

Date

April , 2016

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.