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
ARCH INSURANCE COMPANY

MFDR Tracking Number
M4-17-0670-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 7, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial Compounding Pharmacy has made numerous attempts to have the attached bills processed. Broadspire has yet to approve or deny our bills. Broadspire has not sent Memorial Compounding Pharmacy any type of correspondence, EOB, or payments on any of the attached bills. Proof of timely filing is attached along with all the attempts to have the bills processed. We are now requesting Medical Fee Dispute Resolution."

Amount in Dispute: $1,337.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 30, 2016 to May 15, 2016	Pharmacy Services – Prescription Drug and Compounded Drug Dispensed	$1,337.01	$1,337.01

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 procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines terms related to medical billing and processing.
3. 28 Texas Administrative Code §133.240 sets out procedures for medical bill payments and denials.
4. 28 Texas Administrative Code §134.502 sets out provisions regarding pharmaceutical benefits.
5. 28 Texas Administrative Code §134.503 sets out the pharmacy fee guideline.
6. Texas Labor Code §408.027 sets out provisions regarding payment of health care providers.

7. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, receipt acknowledged November 11, 2016. Per 28 Texas Administrative Code §133.307(d)(1), "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. 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." The insurance carrier has not responded. Accordingly, this decision is based on the information available at the time of review.
8. No explanations of benefits were found with the submitted documentation.

Issues

1. Did the workers' compensation insurance carrier respond to the request for medical fee dispute resolution?
2. Did the insurance carrier timely pay, reduce, deny or take final action on the disputed services?
3. What is the recommended reimbursement for the disputed pharmacy services?
4. Is the requestor entitled to additional reimbursement?

Findings

The health care provider, Memorial Compounding Pharmacy, requested medical fee dispute resolution (MFDR) on November 7, 2016. The provider asserts that the workers' compensation insurance carrier, Arch Insurance Company, has not issued payment or denial for the disputed pharmacy services provided to the injured employee on service dates March 30, 2016 and May 15, 2016.

1. The respondent's Austin carrier representative, Flahive, Ogden & Latson, acknowledged receipt of the request for medical fee dispute resolution on behalf of the insurance carrier, Arch Insurance Company, on November 11, 2016.

   28 Texas Administrative Code §133.307(d) requires that:

   > 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. 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.

   As of the date of this review, the division has not received any response information from the insurance carrier. The division concludes the respondent has failed to meet the requirements of Rule §133.307(d)(1). Accordingly, this decision is based on the information available at the time of review.

2. The requestor contends that the insurance carrier "has not sent . . . any type of correspondence, EOB, or payments" for the disputed pharmacy services.

   Texas Labor Code Sec. 408.027(b), requires that:

   > The insurance carrier must pay, reduce, deny, or determine to audit the health care provider's claim not later than the 45th day after the date of receipt by the carrier of the provider's claim.

   Corresponding Rule §133.240(a) requires that:

   > 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. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

   Final action on a medical bill is defined in 28 Texas Administrative Code §133.2(6) as:

   > (A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement . . . and/or
   > (B) denying a charge on the medical bill.

The following information supports the requester's position that the medical bills for the services in dispute were initially received by the insurance carrier or the carrier's agent:

- A copy of a facsimile transmission confirmation report dated April 6, 2016 indicating successful transmission of the claim for the injured employee for service date March 30, 2016.
- A copy of a facsimile transmission confirmation report dated May 17, 2016 indicating successful transmission of the claim for the injured employee for service date March 15, 2016.
- Four requests by email dated May 11, 2016, asking for status on the outstanding bills as well as a request for an explanation of benefits.
- A request by email dated June 2, asking for status on the outstanding bills.
- A request by email dated July 22, asking for status on the outstanding bills.
- A request by email dated September 2, asking for status on the outstanding bills.
- A request by email dated September 15, asking for status on the outstanding bills.

While the submitted evidence supports the health care provider's timely submission of the medical bills to the insurance carrier, along with a request for explanations of benefits (EOBs), no information was found to support that the insurance carrier took final action or issued EOBs in accordance with the requirements of 28 Texas Administrative Code § 133.240 (a) and (e).

Rule § 133.240(a) requires that:

> An insurance carrier shall take final action after conducting bill review on a complete medical bill . . . **not later than the 45th day** [emphasis added] after the insurance carrier received a complete medical bill.

Rule §133.240 (e) requires that:

> The insurance carrier shall send the explanation of benefits in accordance with the elements required by §133.500 and §133.501 of this title . . . 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 . . .

All workers' compensation insurance carriers are expected to fulfill their duty to take final action as required by law and the division's administrative rules. The insurance carrier failed to do so in this case.

Rule §133.307(d)(2)(F) requires that:

> The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

The insurance carrier's failure to issue explanations of benefits to the health care provider constitutes grounds for the division to find a waiver of defenses at Medical Fee Dispute Resolution.

As no information was presented to support that the insurance carrier had provided to the requestor any denial reasons or defenses in regard to the disputed services prior to the filing of the MFDR request, the division finds the respondent has waived any such defenses. The disputed services will therefore be reviewed for payment according to applicable division rules and fee guidelines.

3. The disputed pharmacy services are in regard to the dispensing of prescription drugs with reimbursement subject to the provisions of 28 Texas Administrative Code §134.503(c), which requires that:

   (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: ((AWP per unit) × (number of units) × 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs: ((AWP per unit) × (number of units) × 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 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).

Reimbursement for the disputed prescription drugs is calculated as follows:

Single drug dispensed March 30, 2016

Ingredient(s)	NDC & Type	Price per Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amount §134.503(c)(2)	Lesser of (c)(1) or (c)(2)
MELOXICAM	38779274601 Generic	$194.67	60	($194.67 × 60) × 1.25 + $4 = $14,604.25	$589.96	$589.96

Compound dispensed May 15, 2016

Ingredient(s)	NDC & Type	Unit Price	Total Units	AWP Formula §134.503(c)(1)	Billed Amount §134.503(c)(2)	Lesser of (c)(1) or (c)(2)
VERSAPRO	38779252903 Brand Name	$3.20	44.8	($3.20 × 44.82) × 1.09 = $156.33	$112.05	$112.05
ETHOXY DIGLYCOL	38779190301 Generic	$0.34	3	($0.34 × 3) × 1.25 = $1.28	$1.03	$1.03
BUPIVACAINE HCL	38779052405 Generic	$45.60	1.2	($45.60 × 1.2) × 1.25 = $68.40	$48.02	$48.02
BACLOFEN	38779038809 Generic	$35.63	3	($35.63 × 3) × 1.25 = $133.61	$102.60	$102.60
MEFENAMIC ACID	38779066906 Generic	$123.60	1.8	($123.60 × 1.8) × 1.25 = $278.10	$222.48	$222.48
MELOXICAM	38779274601 Generic	$194.67	0.18	($194.67 × 0.18) × 1.25 = $43.80	$35.04	$35.04
FLURBIPROFEN	38779036209 Generic	$36.58	6	($36.58 × 6) × 1.25 = $274.35	$210.90	$210.90
		Total Units:	60		Subtotal:	$732.12
					+ $15 compound fee = **Total**:	$747.12

4. The maximum allowable reimbursement is $1,337.08. The insurance carrier has paid $0.00. The requestor is seeking $1,337.01. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

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 $1,337.01.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 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 $1,337.01, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	December 15, 2016
Signature	Medical Fee Dispute Resolution Officer	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.