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 COMPANY

MFDR Tracking Number
M4-17-1564-0

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 26, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached bills are outstanding as we have not received any correspondence from the insurance carrier . . . We are now requesting Medical Fee Dispute Resolution."

Amount in Dispute: $457.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier is in the process of sending additional payment to the provider."

Response Submitted by: Flahive, Ogden & Latson, Attorneys At Law, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 16, 2016	Pharmacy services – prescription drug dispensed	$457.50	$457.50

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 §133.210 sets out requirements regarding medical documentation.
4. 28 Texas Administrative Code §133.240 sets out procedures for medical bill payments and denials.
5. 28 Texas Administrative Code §134.502 sets out provisions regarding pharmaceutical benefits.
6. 28 Texas Administrative Code §134.503 sets out the pharmacy fee guideline.
7. Texas Labor Code §408.027 sets out provisions regarding payment of health care providers.

8. No explanations of benefits were submitted for review by either party. 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. As will be discussed further below, because the respondent has not supported that the insurance carrier took final action on the disputed bills and further failed to support that the insurance carrier communicated to the requestor any denial reasons or defenses prior to the filing of the request for MFDR, the division finds below that the respondent has waived any such defenses. Any new denial reasons or defenses presented in the insurance carrier's response shall not be considered in this review.

Issues

1. Did the respondent support that additional payment was sent?
2. Did the insurance carrier timely pay, reduce, deny or take final action on the services in dispute?
3. What is the recommended reimbursement for the disputed pharmacy services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier's response states that "The carrier is in the process of sending additional payment to the provider. If the provider should receive the full amount it is requesting through medical dispute resolution, then the carrier requests that the provider withdraw its request for medical dispute resolution."

   The division contacted the requestor to inquire if payment had been received from the carrier. The requestor responded that no payment had been received.

   The division subsequently contacted the respondent's attorney (Flahive, Ogden & Latson) by e-mail to inquire about the alleged payment and to request an explanation of benefits. The attorney did not respond to the division's request.

   Review of the "print screen" document submitted as evidence by the respondent finds the information to be illegible.

   Based on the preponderance of evidence submitted for review, the division concludes the respondent has failed to support that it sent additional payment to the provider.

2. The requestor contends they "have not received any correspondence from the insurance carrier" for the disputed pharmacy services.

   Rule §133.307(c)(2)(K) requires that the requestor shall provide with the request for MFDR:

   > a paper copy of each explanation of benefits (EOB) related to the dispute . . . or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB

   Rule §133.210(e) states that:

   > It is the insurance carrier's obligation to furnish its agents with any documentation necessary for the resolution of a medical bill. The Division considers any medical billing information or documentation possessed by one entity to be simultaneously possessed by the other.

   The requester presented copies of certified mail receipts, signed for by Zurich, supporting that the insurance carrier, or the carrier's agent, received the pharmacy bills for the services in dispute. The requestor also submitted convincing documentation providing evidence of insurance carrier receipt of the request for EOBs. The division concludes that the requestor has met the requirements of Rule §133.307(c)(2)(K).

   Texas Labor Code Section 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.

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 . . .

Rule §133.307(d)(2)(B) requires that upon receipt of the request for medical fee dispute resolution, the respondent shall provide any missing information not provided by the requestor and known to the respondent, including:

> a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider in accordance with this chapter, related to the health care in dispute not submitted by the requestor or a statement certifying that the respondent did not receive the health care provider's disputed billing prior to the dispute request.

The insurance carrier did not submit copies of any EOBS as required by Rule §133.307(d)(2)(B).

While the submitted evidence supports the health care provider's timely submission of the pharmacy bill(s) to the insurance carrier—along with a request for an EOB—no information was found to support the insurance carrier ever took final action or issued EOBs accordance to the requirements of Rules § 133.240 (a) and (e). The division concludes the respondent failed to meet the requirements of the above rules.

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.

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

   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:

   Prescription drug dispensed October 16, 2016

Ingredient(s)	NDC & Type	Unit Price	Units	AWP Formula §134.503(c)(1)	Billed Amount §134.503(c)(2)	Lesser of (c)(1) or (c)(2)
BACLOFEN	69746010395 Generic	$80.00	5	($80.00 × 5) × 1.25 +$4 = $504.00	$457.50	$457.50

4. The maximum allowable reimbursement is $457.50. The insurance carrier has paid $0.00, leaving an amount due to the requestor of $457.50. 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 $457.50.

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 $457.50, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	April 28, 2017
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 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.