



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

Trumbull Insurance Company

MFDR Tracking Number

M4-18-2698-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

March 26, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The above claimant received medication ... The carrier denied the reconsideration based on CLAIM NOT PROCESSED. Bill for date of service (08/14/2017) was processed on (09/13/2017)."

Amount in Dispute: \$798.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Compounds are considered off label as many ingredients are not FDA approved for topical use, efficacy has not been proven ... Sent UR needed letter to MD."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: August 14, 2017, Pharmacy Service - Compound, \$798.06, \$798.06

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 the requirements for payment, reduction, or denial of medical bills.
3. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
4. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
• 85 – Claim not processed

- P2 – Not a work related injury/illness and thus not the liability of the workers’ compensation carrier.

Issues

1. Did Trumbull Insurance Company (Trumbull) raise a new defense in its position statement?
2. Is this dispute subject to dismissal for liability?
3. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the compound in question?

Findings

1. Memorial is seeking reimbursement for a compound dispensed on August 14, 2017. In its position statement, The Hartford argued on behalf of Trumbull, “TX requires prescribers to submit requests through UR and not the pharmacy. Sent UR needed letter to MD.”

The insurance carrier is required to address only those issues raised before the request for medical fee dispute resolution (MFDR) in its position statement.¹

Submitted documentation fails to support that Trumbull presented a medical necessity denial to Memorial² before the date that a request for MFDR was filed. The division finds that this argument raised in The Hartford’s position statement constitutes a new defense. This new defense shall not be considered for review.

2. Trumbull submitted an explanation of benefits dated January 27, 2018, with claim adjustment reason code, P2 – “Not a work related injury/illness and thus not the liability of the workers’ compensation carrier.”

The division notes that Trumbull failed to present a denial for liability within 45 days from the date it received the complete pharmacy bill.³ Therefore, the division finds that this dispute is not subject to dismissal based on liability.

3. The division concludes that Trumbull’s denial reasons are not supported. Consequently, the compound in question is eligible for reimbursement.

The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately.⁴ Each ingredient is listed below with its reimbursement amount.⁵ The calculation of the total allowable amount is as follows:

Ingredient	NDC & Type	Price/ Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Flurbiprofen	38779036209 Generic	\$36.58	6.0	\$274.35	\$219.48	\$219.48
Meloxicam	38779274601 Generic	\$194.67	0.18	\$43.80	\$35.04	\$35.04
Mefenamic Acid	38779066906 Generic	\$123.60	1.8	\$278.10	\$222.48	\$222.48
Baclofen	38779038809 Generic	\$35.63	3.0	\$133.61	\$106.89	\$106.89
Bupivacaine HCL	38779052405 Generic	\$45.60	1.2	\$68.40	\$54.72	\$54.72
Ethoxy Diglycol	38779190301 Generic	\$0.342	3.0	\$1.28	\$1.03	\$1.03

¹ 28 Texas Administrative Code §133.307(d)(2)(F)

² 28 Texas Administrative Code §133.240

³ State Office of Risk Management v. Lawton, 295 S.W.3d 646 (Tex. 2009), <https://caselaw.findlaw.com/tx-supreme-court/1388209.html>

⁴ 28 Texas Administrative Code §134.502(d)(2)

⁵ 28 Texas Administrative Code §134.503(c)

Versapro Cream	38779252903 Brand Name	\$3.20	44.82	\$156.33	\$143.42	\$143.42
Compound Fee	NA	NA	NA	\$15.00	\$15.00	\$15.00
					Total	\$798.06

The total reimbursement is therefore \$798.06. 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 \$798.06.

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 \$798.06, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	August 2, 2018
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.