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
American Zurich Insurance Company

MFDR Tracking Number
M4-18-2920-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 16, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "You denied this claim indicating that the claim lacks information which is needed for adjudication."

Amount in Dispute: $726.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is uncontested that Requestor failed to request preauthorization, and failed to obtain authorization from the Respondent or an order from the commissioner."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 28, 2017	Pharmaceutical Compound	$726.62	$726.62

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 §133.10 sets out the requirements for a complete pharmacy bill.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
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:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation.

Issues

1. Did American Zurich Insurance Company (Zurich) raise a new defense in its position statement?
2. Is the Zurich's reason for denial of payment supported?
3. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the compound in dispute?

Findings

1. Memorial is seeking reimbursement for a compound dispensed on November 28, 2017. In its position statement, Flahive, Ogden & Latson argued on behalf of Zurich, that the compound in dispute required preauthorization.

   The insurance carrier may only address denial reasons raised before the request for medical fee dispute resolution (MFDR) was requested. Any other issues raised in the response will not be considered.[1]

   The documents submitted to the Texas Department of Insurance, Division of Workers' Compensation (DWC) do not show that Zurich gave denial reasons related to preauthorization to Memorial before the date the request for MFDR was filed.[2] The DWC concludes that these arguments in Flahive, Ogden & Latson's position statement will not be considered for review because they are new defenses.

2. Zurich denied the disputed compound with claim adjustment reason code 16 – "CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION."

   Review of the submitted pharmacy bills finds no submission or billing errors.[3] Flahive, Ogden & Latson failed to support this denial in its position statement.

3. Because Zurich failed to support its denial of reimbursement, Memorial is entitled to reimbursement in accordance with applicable rules and laws.

   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:

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Meloxicam	38779274601	G	$194.67	0.18	$43.80	$35.04	$35.04
Flurbiprofen	38779036209	G	$36.58	4.8	$219.48	$175.58	$175.58
Tramadol	38779237409	G	$36.30	6	$272.25	$217.80	$217.80
Cyclobenzaprine	38779039509	G	$46.33	1.8	$104.25	$83.39	$83.39
Bupivacaine	38779052405	G	$45.60	1.2	$68.40	$54.72	$54.72
Ethoxy Diglycol	38779190301	G	$0.34	3	$1.28	$1.03	$1.03
Versapro Cream	38779252903	B	$3.20	45.02	$157.03	$144.06	$144.06
Fee	NA	NA	NA	NA	$15.00	$15.00	$15.00
						Total	$726.62

   The total allowable reimbursement for the compound in dispute is $726.62. 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 $726.62.

[1] 28 Texas Administrative Code §133.307(d)(2)(F)
[2] 28 Texas Administrative Code §133.240 explains how the insurance carrier is required to introduce denials and payment reductions to the requestor.
[3] 28 Texas Administrative Code §133.10(f)(3)
[4] 28 Texas Administrative Code §134.502(d)(2)
[5] 28 Texas Administrative Code §134.503(c)

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 $726.62, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	September 28, 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.