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 Co

MFDR Tracking Number
M4-18-3024-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 23, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Texas Labor Code Section 408.027 (b) requires that the carrier must pay, reduce, deny or determine to audit the health provider's claim no later than the 45th day after the date of receipt by the carrier. Memorial did not receive any correspondence as per rule..."

Amount in Dispute: $583.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As Memorial has not, before filing for medical fee dispute resolution, submitted this bill to the PBM, the bill is currently under review per that contract. The Carrier will supplement this response with the PBM's response to the bill."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 25, 2017	Pharmacy Services - Compounds	$583.89	$583.89

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 §134.502 sets out the procedures for pharmaceutical benefits.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. Neither party submitted any explanation of benefits for the services in dispute.

Issues

1. Did the respondent raise a new issue?
2. What rule is applicable to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307 (d)(F) states in pertinent parts,

   Responses. 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.

   > 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. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section.

   As none of the defenses raised by the respondent were presented to the requestor prior to the date the MFDR request was filed, per the above these defenses will not be considered in this review.

   The respondent states, "the bill is currently under review per that contract. The Carrier will supplement this response with the PBM's response to the bill." No additional information was received by the Division. The services in dispute will be reviewed per applicable rules and fee guidelines.

2. The requestor is seeking reimbursement of $583.89 for a compound dispensed on October 25, 2017. 28 Texas Administrative Code §134.503 applies to the compounds in dispute and states, in pertinent part:

   (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) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
   (B) Brand name drugs: ((AWP per unit) x (number of units) x 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

   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). Each ingredient is listed below with its corresponding reimbursement amount as applicable.

Ingredient	NDC	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	$123.60	6	$219.48	$219.48	$219.48
Meloxicam	38779036209	$36.48	0.18	$43.80	$35.04	$35.04
Mefenamic Acid	38779066906	$123.60	1.8	$278.10	$222.48	$222.48
Baclofen	38779038809	$35.63	3	$133.61	$106.89	$106.89
					Total	$583.89

The total reimbursement is $583.89. 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 $583.89.

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 $583.89, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		September 11, 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.