



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

Zurich American Insurance Company

MFDR Tracking Number

M4-18-3776-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

June 4, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the reconsideration based on unresolved issues of extent of injury. A call was placed to carrier to confirm patient demographics as well as compensability. We were not notified of any disputes or PLN11 filed."

Amount in Dispute: \$702.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Memorial should send its bill directly to the PBM ... In this case and upon request for payment by Memorial, payment was stopped in the face of an Adverse Determination ... The Requestor did not request and receive preauthorization for this investigational or experimental compound formulation."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 15, 2017	Compound Medication	\$702.68	\$702.68

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 (DWC).

Background

1. 28 Texas Administrative Code §133.20 sets out the procedures for submitting a medical bill.
2. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
5. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.

6. The insurance carrier denied payment with the following claim adjustment reason code:
 - P6 – Based on entitlement to benefits.

Issues

1. Did Memorial Compounding Pharmacy (Memorial) submit the pharmacy bill in question to the insurance carrier?
2. Did Zurich American Insurance Company (Zurich) raise new defenses in its response?
3. Is the insurance carrier's reason for denial of payment supported?
4. Is Memorial entitled to reimbursement for the compound in question?

Findings

1. Memorial is seeking reimbursement for a compound dispensed on September 15, 2017. In its position statement, Flahive, Ogden & Latson, on behalf of the insurance carrier, stated that Memorial failed to file the bill to the insurance carrier's pharmacy benefit manager.

The health care provider is required to submit a medical bill to the insurance carrier.¹ Documentation submitted to the Texas Department of Insurance, Division of Workers' Compensation (DWC) finds that Memorial submitted the bill in question to Zurich on or about October 4, 2017.

The evidence submitted in this dispute is not sufficient to support that Memorial failed to submit a medical bill to the insurance carrier.

2. In its position statement, Flahive, Ogden & Latson raised defenses based on medical necessity and preauthorization for non-payment of the disputed compound.

The response from the insurance carrier is required to address only the denial reasons presented to the requestor² the request for medical fee dispute resolution (MFDR) was filed with the DWC. Any new denial reasons or defenses raised shall not be considered in this review.³

The submitted documentation does not support that a denial based on the issues listed above were provided to Memorial before this request for MFDR was filed. Therefore, the DWC will not consider these arguments in the current dispute review.

3. The insurance carrier denied the disputed compound based on compensability. A dispute regarding the relatedness to the compensable injury must be resolved prior to a request for medical fee dispute.⁴

The respondent is required to attach a copy of any related Plain Language Notice (PLN) if the medical fee dispute involves compensability or liability. Review of the submitted documentation finds that Flahive, Ogden & Latson failed to attach a copy of a related PLN on behalf of the insurance carrier to support a denial based on compensability.

The dispute in question is not subject to dismissal as this denial reason was not sufficiently supported.

4. Because the insurance carrier failed to sufficiently support its denial of reimbursement, Memorial is entitled to reimbursement.

The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately.⁵ Each ingredient is listed below with its reimbursement amount.⁶ The calculation of the total allowable amount is as follows:

¹ 28 Texas Administrative Code §133.20(a)

² 28 Texas Administrative Code §133.240

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

⁴ 28 Texas Administrative Codes §§133.305(b) and 133.307(c)(1)(B)(i)

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

⁶ 28 Texas Administrative Code §134.503(c)

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Baclofen	38779038809	G	\$35.63	5.4	\$240.50	\$190.78	\$190.78
Amantadine	38779041105	G	\$24.23	3	\$90.84	\$72.69	\$72.69
Gabapentin	38779246109	G	\$59.85	3.6	\$269.33	\$204.66	\$204.66
Bupivacaine	38779052405	G	\$45.60	1.2	\$68.40	\$54.72	\$54.72
Amitriptyline	38779018904	G	\$18.24	1.8	\$41.04	\$32.83	\$32.83
Ethoxy Diglycol	38779190301	G	\$0.34	4.2	\$1.80	\$1.44	\$1.44
Versapro Cream	38779252903	B	\$3.20	40.8	\$142.31	\$130.56	\$130.56
Fee	NA	NA	NA	NA	\$15.00	\$15.00	\$15.00
						Total	\$702.68

The total reimbursement is therefore \$702.68. 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 \$702.68.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor \$702.68, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	November 14, 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 DWC 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.