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
Hartford Fire Insurance Company

MFDR Tracking Number
M4-18-4028-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 19, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier is required to provide a response of the bill in order for the HealthCare Provider to rebuttal properly."

Amount in Dispute: $277.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per protocol, claim is not approved pending review through UR."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 20, 2017	Tramadol HCl 50 mg Tablets	$74.16	$24.82
October 20, 2017	Meloxicam 15 mg Tablets	$202.85	$185.69
	Total	$277.01	$210.51

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 §133.240 sets out the procedures for payment or denial of a medical 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 denied payment based on compensability.

Issues

1. Is this dispute subject to dismissal based on compensability?
2. Did the insurance carrier raise a new defense in its response?
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 October 20, 2017. The insurance carrier processed and denied the disputed compound, in part, based on compensability. Per submitted explanations of benefits dated November 13, 2017, the pharmacy bill was originally received by the insurance carrier on or before that date. These explanations of benefits did not raise an issue of compensability.

   Explanation of benefits, dated March 27, 2018 denied the compound based on compensability. This explanation of benefits is more than 45 days after the date the original complete bill was received.[1]

   The insurance carrier has the obligation to dispute whether a treatment was for the compensable injury within 45 days after receiving a complete medical bill.[2] The DWC notes that the insurance carrier failed to provide evidence that a denial for compensability was presented to Memorial within 45 days from the date it received the complete pharmacy bill. Therefore, the DWC finds that the dispute in question is not subject to dismissal based on this denial reason.

2. In its position statement, The Hartford, on behalf of the insurance carrier, argued that the "claim [was] not approved pending review through UR."

   The response from the insurance carrier is required to address only the denial reasons presented to the requestor the request for medical fee dispute resolution (MFDR) was filed with the Texas Department of Insurance, Division of Workers' Compensation (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 medical necessity was provided to Memorial before this request for MFDR was filed. Therefore, the DWC will not consider this argument in the current dispute review.

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

   The reimbursement for the drugs considered in this dispute is calculated as follows[4]:

   - Tramadol HCl 50 mg tablets: (0.83289 x 20 x 1.25) + $4.00 = $24.82
   - Meloxicam 15 mg tablets: (4.845 x 60 x 1.25) + $4.00 = $185.69

   The total reimbursement is therefore $210.51. 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 $210.51.

[1] 28 Texas Administrative Code §133.240(a)
[2] "A carrier has up to forty-five days from the date it receives a complete medical bill to dispute whether that treatment was necessary." State Office of Risk Management v. Lawton, 295 S.W.3d 646 (Tex. 2009), https://caselaw.findlaw.com/tx-supreme-court/1388209.html
[3] 28 Texas Administrative Code §133.307(d)(2)(F)
[4] 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 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 $210.51, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	December 13, 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.