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
Harris County

MFDR Tracking Number
M4-18-4348-01

Carrier's Austin Representative
Box Number 21

MFDR Date Received
July 17, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The original bill was submitted and received to carrier on 10/18/2017. 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: $498.15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…The Provider then submitted a second bill and called it a reconsideration of the first bill."

Response submitted by: Thornton Biechlin Reynolds & Guerra

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 14, 2017	Compound Medication	$498.15	$0.00

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 guidelines for pharmacy services.
3. 28 Texas Administrative Code §133.20 sets out requirements of medical bill submission.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization/notification absent
   - 29 – The time limit for filing has expired

- 193 – Original payment decision is being maintained. Upon review, it was determined that this calims was processed properly.

Issues

1. Is the insurance carrier's reasons for denial supported?

Findings

1. The requestor is seeking $498.15 for a compound medication dispensed on October 14, 2017. The carrier states, "Respondent does not owe reimbursement for this bill as it was not a proper bill for a compound drug."

   Review of the submitted documentation finds;

   DWC066 with date of billing 10/14/2017 with the drug name and strength listed in box 27 as MELO03FLUR8TRAM10CYCLO3BUP2% for a total of $150.00. The claim was received on October 23, 2017. This description does not match the drug name associated with the NDC number of 38779-2746-01 found in box 22 or Meloxicam.

   28 Texas Administrative Code §134.502 (d) states in pertinent part,

   > Pharmacies and pharmacy processing agents shall submit bills for pharmacy services in accordance with Chapter 133 (relating to General Medial Provisions) and Chapter 134 (relating to Benefits-Guidelines for Medical Services, Charges, and Payments.
   >
   > (1) Health care providers shall bill using national drug codes (NDC) when billing for prescription drugs.
   >
   > (2) Compound drugs shall be billed by listing each drug included in the compound and calculating the charge for each drug separately.

   This billed description does not meet the requirements of 28 Texas Administrative Code §134.502 (d).

   Additional review finds;

   DWC066 with date of billing 10/14/2017 that includes Meloxicam, Flurbiprofen, Tramadol, Cyclobenzaprine and Bupivicaine for a total of $498.15. This bill was received by the carrier on May 25, 2018.

   28 Texas Administrative Code §133.20 (b) states in pertinent part,

   > Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.

   The requestor submitted a USPS Tracking # document but there is no date to support when it was sent or received. The requestor also included a "Domestic Return Receipt" showing date of delivery 5/24/2018. This supports the submission of the bill but not within 95 days from the date of service.

   No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 the division has determined the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		August 15, 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.