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 RX

**Respondent Name**
Zenith Insurance Company

**MFDR Tracking Number**
M4-18-4399-01

**Carrier's Austin Representative**
Box Number 47

**MFDR Date Received**
July 23, 2018

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "**After reviewing the explanation of benefits, it indicates that carrier paid $0.00 and not the full amount of $977.61.** This claim should be processed with the full amount billed as per **Administrative Labor Code 134.503(c)**."

**Amount in Dispute:** $977.61

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The Claims Examiner has confirmed that no payment is due to Memorial Compounding RX as the disputed services should have been billed through Zenith's PBM, TMESYS."

**Response Submitted by:** The Zenith

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| November 22, 2017 | Gabapentin 100 mg Capsules | $89.63 | $44.16 |
| November 22, 2017 | Naproxen 500 mg Tablets | $129.07 | $93.46 |
| November 22, 2017 | Tizanidine HCl 4 mg Tablets | $101.46 | $58.95 |
| November 22, 2017 | Methylprednisolone Dose Pack | $87.52 | $41.52 |
| November 22, 2017 | Compound Medication | $569.93 | $569.93 |
| | Total | $977.61 | $808.02 |

## *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 §133.210 sets out the documentation requirements for medical bills.
2. 28 Texas Administrative Code §133.20 sets out the procedures for submitting a medical bill.

3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
5. Texas Labor Code §408.021 establishes entitlement to medical benefits.
6. Texas Insurance Code §1305.101 defines the duties of networks to provide medical treatment.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - DP2 – All Zenith pharmacy bills should be submitted by the dispensing pharmacy to TMESYS using one of the methods outlined below.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - Notes: "CHARGES DENIED. DISPENSING PHARMACY IS EITHER IN ZENITH'S PBM AND REQUIRED TO BILL THROUGH THE PBM OR DOES NOT PARTICIPATE IN THE PBM PARTICIPATING PHARMACIES MUST SUBMIT ALL BILLS TO ZENITH'S PBM TMESYS"

**Issues**

1. Is the insurance carrier's denial of payment supported?
2. Is Memorial Compounding Rx (Memorial) entitled to reimbursement for the disputed drugs?

**Findings**

1. Memorial is seeking reimbursement for drugs dispensed on November 22, 2017. On explanations of benefits dated December 5, 2017, and April 25, 2018, the insurance carrier stated, "the disputed services should have been billed through Zenith's PBM."

   The DWC considers any documentation submitted to be simultaneously possessed by the insurance carrier and its agents, and it is the insurance carrier's responsibility to provide its agents with any documentation needed to adjudicate a medical bill.[1]

   The documentation supports that Memorial submitted a medical bill to the insurance carrier as required.[2] The DWC concludes that it was the insurance carrier's responsibility to provide its agent with any documentation it received to adjudicate a medical bill.

2. Because the insurance carrier failed to support its denial of payment, Memorial is entitled to reimbursement for the drugs in question.

   The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately.[3] Each ingredient is listed below with its reimbursement amount.[4] 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 |
|---|---|---|---|---|---|---|---|
| Gabapentin USP | 38779246109 | G | $59.85 | 3 | $224.44 | $179.55 | $179.55 |
| Amitriptyline HCl | 38779018904 | G | $18.24 | 2.4 | $54.72 | $43.78 | $43.78 |
| Amantadine HCl | 38779041105 | G | $24.23 | 4.8 | $145.35 | $116.30 | $116.30 |
| Flurbiprofen | 38779036209 | G | $36.58 | 4.8 | $219.48 | $175.58 | $175.58 |
| Bupivacaine HCl | 38779052405 | G | $45.60 | 1.2 | $68.40 | $54.72 | $54.72 |
| | | | | | | Total | $569.93 |

   The reimbursement for the remaining medications considered in this dispute is calculated as follows[5]:

   - Gabapentin 100 mg capsules: (0.5355 x 60 x 1.25) + $4.00 = $44.16

[1] 28 Texas Administrative Code §133.210(e)
[2] 28 Texas Administrative Code §133.240
[3] 28 Texas Administrative Code §134.502(d)(2)
[4] 28 Texas Administrative Code §134.503(c)
[5] 28 Texas Administrative Code §134.503(c)

- Naproxen 500 mg tablets: (1.1928 x 60 x 1.25) + $4.00 = $93.46
- Tizanidine HCl 4 mg tablets: (1.46524 x 30 x 1.25) + $4.00 = $58.95
- Methylprednisolone Dose Pack: (1.42952 x 21 x 1.25) + $4.00 = $41.52

The total reimbursement is therefore $808.02. This amount is recommended.

**Conclusion**

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $808.02.

## *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 $808.02, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

| | Laurie Garnes | March 12, 2020 |
|---|---|---|
| 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 DWC 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**.