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
DOLGENCORP OF TEXAS, INC.

MFDR Tracking Number
M4-18-4474-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 25, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "the carrier processed and paid only PARTIAL of the total bill. … This claim should be processed with the full amount billed as per Administrative Labor Code 134.503(c)."

Amount in Dispute: $234.55

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the Self-Insured had a comprehensive Drug Regimen Review performed and offered it to the treating physician for comment. … That review demonstrated this compound is not medically necessary and appropriate. … Nevertheless, upon reconsideration, the Self-Insured has issued additional payment in the amount of $186.72."

Response Submitted by: Flahive, Odgen & Latson, Attorneys at Law, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 28, 2017	Pharmacy Services	$234.55	$201.72

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 §134.503 sets out the fee guideline for pharmacy services.
3. 28 Texas Administrative Code §134.530 sets out requirements for use of the division's closed formulary.
4. 28 Texas Administrative Code Chapter 19 sets out requirements for utilization review.
5. The insurance carrier denied payment based on the following claim adjustment codes:
   - 93 – Paid: no modification to the information provided on the medical bill: payment made pursuant to the written contractual arrangement Dollar General.

Findings

The division emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

1. Are there any outstanding issues of medical necessity?

The response states, "the Self-Insured had a comprehensive Drug Regimen Review performed and offered it to the treating physician for comment. … That review demonstrated this compound is not medically necessary and appropriate. … Nevertheless, upon reconsideration, the Self-Insured has issued additional payment … "

Rule §134.530(g) provides that "drugs that do not require preauthorization are subject to retrospective review for medical necessity in accordance with §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) and §133.240 of this title (relating to Medical Payments and Denials), and applicable provisions of Chapter 19 of this title."

Retrospective review of the medical necessity for disputed pharmaceutical services requires utilization review in accordance with the requirements of 28 Texas Administrative Code Chapter 19.

The submitted "Drug Regimen Review" is dated September 8, 2017. The pharmacy dispensed the disputed compound November 28, 2017. The report is therefore not related to any *retrospective* review of the services in dispute. The division finds the report does not meet the requirements of rule §134.530(g) or 28 Administrative Code Chapter 19.

The respondent did not provide documentation to support utilization review in accordance with the requirements of 28 Texas Administrative Code Chapter 19. The division concludes there are no outstanding issues of medical necessity.

2. *Did the respondent raise new defenses or denial reasons after the request for MFDR?*

The respondent raises new denial reasons and defenses in the position statement that were not presented to the requestor prior to the filing of the request for medical fee dispute resolution.

Rule §133.307(d)(2)(F) requires that "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."

Pursuant to Rule §133.307(d)(2)(F), the insurance carrier's failure to give notice to the pharmacy of specific codes or explanations for reduction or denial of payment during bill review or reconsideration constitutes grounds for the division to find a waiver of defenses during Medical Fee Dispute Resolution. The division finds such a waiver here.

Upon review of the insurance carrier response, the division finds the respondent raises new denial reasons or defenses of which the carrier failed to give any notice to the pharmacy during the bill review process or prior to the filing of this dispute. Consequently, the division concludes the respondent has waived the right to raise these new denial reasons or defenses during MFDR. Any such new defenses or denial reasons will not be considered in this review.

3. Is additional reimbursement due?

Review of the submitted explanations of benefits (EOB) finds no documentation of any EOBs in response to the pharmacy's initial billing. Upon reconsideration, the carrier issued payment of $32.83 for Amitryptaline HCL, one of the components in the disputed compound. The EOB indicates the item paid was "Paid: no modification to the information provided on the medical bill …" This item was paid in the amount of the full billed charge of $32.83 for that item. However, the EOB did not address the other disputed drugs listed on the medical bill.

Reimbursement for the remaining items is subject to Rule at 28 Texas Administrative Code §134.503(c), which requires that the insurance carrier shall reimburse the lesser of: (1) the fee established by the division's applicable formula 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; or (2) the amount billed to the insurance carrier.

Reimbursement is calculated as follows:

Ingredient(s)	NDC & Type	Unit Price	Total Units	AWP Formula §134.503(c)(1)	Billed Amount §134.503(c)(2)	Lesser of (c)(1) or (c)(2)
BUPIVACAINE HCL	38779052405 Generic	$45.60	1.2	($45.60 × 1.2) × 1.25 = $68.40	$54.72	$54.72
AMITRIPTYLINE HCL	38779018904 Generic	$18.24	1.8	($18.24 × 1.8) × 1.25 = $41.04	$32.83	$32.83
ETHOXY DIGLYCOL	38779190301 Generic	$0.34	4.2	($0.34 × 4.2) × 1.25 = $1.80	$1.44	$1.44
VERSAPRO	38779252903 *Brand*	$3.20	41	($3.20 × 40.8) × 1.09 = $142.31	$130.56	$130.56
		Total Units:	48		Subtotal:	$219.55
					+ $15 compound fee = **Total**:	$234.55

The total reimbursement for the medication in dispute is $234.55. The submitted documentation supports the respondent paid $32.83 for the Amitriptyline HCL component, date of service November 28, 2017, leaving a remaining balance due to the requestor of $201.72. 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 $201.72.

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 $201.72, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	February 15, 2019
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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.