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
M4-18-4476-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 25, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The original claim was denied on 12/5/2017 code 93 based on partial payment. An appeal was submitted on 4/2/2018… EOB … states that code D based on duplicate bill is the new denial reason. There were no additional code changes or services rendered. Therefore, the carrier cannot change from the original denial."

Amount in Dispute: $702.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "upon reconsideration, the Self-Insured has issued additional payment in the amount of $464.07…"

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

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 15, 2017	Pharmacy Services	$702.68	$479.07

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. The insurance carrier denied payment based on the following claim adjustment codes:
   - 10 – [No description of this denial reason was provided in the materials submitted for review to MFDR]
   - 93 – Paid: no modification to the information provided on the medical bill: payment made pursuant to the written contractual arrangement Dollar General.
   - D – Duplicate Bill
   - O – Denial after reconsideration

Findings

Based on the information presented to MFDR by the parties up to the date of review, the division makes the following findings. Even though not all the evidence was discussed, it was considered.

1. Did the carrier reimburse Memorial for the disputed services?

Memorial Compounding Pharmacy (Memorial) asserts the carrier has made partial payment for the services in dispute. Review of the submitted explanations of benefits (EOBs) finds the carrier issued payment for:

- Baclofen $190.78
- Amitriptyline $32.83

The respondent's position statement asserts that "upon reconsideration, the Self-Insured has issued additional payment in the amount of $464.07…" However, the respondent provided documentation to support only the above two payments, including explanations of benefits for items that are not part of this dispute.

2. Did the self-insured payer raise new defenses or denial reasons in the MFDR response that were not previously presented to the health care provider before the request for medical fee dispute resolution?

Review of the documentation presented by the respondent finds that the respondent has raised new defenses or denial reasons that were not present on the explanations of benefits submitted to the health care provider.

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."

Review of the submitted information finds no documentation to support that such new defenses or denial reasons were presented to the health care provider during the bill review process or during reconsideration or at any time before the request for MFDR was filed with the division and the other party.

The documentation supports that the new defenses or denial reasons were presented to the prescribing physician but not to the pharmacy that provided the services in dispute here.

Failure of the insurance carrier (or the self-insured employer) to give notice to the health care provider of specific denial reasons or defenses during the bill review and reconsideration process is grounds for the division to find a waiver of such defenses at MDFR, and the division finds such a waiver here.

The division concludes the self-insured employer has waived the right to raise new defenses or denial reasons pursuant to Rule §133.307(d)(2)(F). Any such new defenses or denial reasons will not be considered in this review.

3. Is additional reimbursement due?

Rule §134.503(c) requires the insurance carrier to reimburse prescription drugs the lesser of: (1) the fee established by formula in the rule based on the average wholesale price (AWP) as reported by nationally recognized pharmaceutical pricing data; or (2) the amount billed.

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)
BACLOFEN	38779038809 Generic	$35.63	5.4	($35.63 × 5.4) × 1.25 = $240.50	$190.78	$190.78
AMANTADINE HCL	38779041105 Generic	$24.23	3	($24.23 × 3) × 1.25 = $90.84	$72.69	$72.69
GABAPENTIN	38779246109 Generic	$59.85	3.6	($59.85 × 3.6) × 1.25 = $269.33	$204.66	$204.66
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:		60		Subtotal:	$687.68
					+ $15 compound fee = **Total**:	$702.68

The total reimbursement for the medication in dispute is $702.68. Documentation was submitted to support payment of $223.61, leaving a balance due to the requestor of $479.07. This amount is recommended.

Conclusion

For the reasons stated above, the division concludes the requestor has established that additional reimbursement is due. As a result, the amount ordered is $479.07.

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 $479.07, 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 22, 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.