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 Pharmacy

Respondent Name
Sentinel Insurance Company Ltd

MFDR Tracking Number
M4-18-4576-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
July 31, 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: $726.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Compounds are considered off label as many ingredients are not FDA approved for topical use. A request for information was sent to Angelo Parmeswaran MD. There are no medical records recieved that addresses the use of this compounded medication. The claim was closed with pay through date of 9/30/17 as MMI reached."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 11, 2017	Compound Medication	$726.62	$726.62

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 §133.240 sets out the procedures for payment or denial of medical bills.
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 reduced payment for the disputed services with the following claim adjustment codes:
   - 85 – Claim not processed

- 27 – Expenses incurred after coverage terminated.

Issues

1. Did the insurance carrier raise a new defense in its response?
2. Is this dispute subject to dismissal due to the compensability of the injury?
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 December 11, 2017. In its position statement, The Hartford, on behalf of the insurance carrier, argued that the compound was denied for lack of documentation.

   The response from the insurance carrier is required to address only the denial reasons presented to the requestor before the 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.[1]

   The submitted documentation does not support that a denial based on lack of documentation was provided to Memorial before this request for MFDR was filed. Therefore, the DWC will not consider this argument in the current dispute review.

2. The insurance carrier denied the disputed compound, in part, based on the liability of the injury. Per submitted explanation of benefits date-stamped by Memorial on January 22, 2018, the pharmacy bill was originally received by the insurance carrier on or before this date. This explanation of benefits did not raise the issue of liability.

   Explanation of benefits dated June 27, 2018, denying the compound based on liability is more than 45 days after the date the original complete bill was received.[2]

   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.[3] The DWC notes that the insurance carrier failed to present evidence of a denial for compensability 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.

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

   The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately.[4] Each ingredient is listed below with its reimbursement amount.[5] The calculation of the total allowable amount is as follows:

[1] 28 Texas Administrative Code §133.307(d)(2)(F)
[2] 28 Texas Administrative Code §133.240(a)
[3] "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
[4] 28 Texas Administrative Code §134.502(d)(2)
[5] 28 Texas Administrative Code §134.503(c)

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Meloxicam	38779274601	G	$194.67	0.18	$43.80	$35.04	$35.04
Flurbiprofen	38779036209	G	$36.58	4.8	$219.48	$175.58	$175.58
Tramadol	38779237409	G	$36.30	6	$272.25	$217.80	$217.80
Cyclobenzaprine	38779039509	G	$46.33	1.8	$104.24	$83.39	$83.39
Bupivacaine	38779052405	G	$45.60	1.2	$68.40	$54.72	$54.72
Ethoxy Diglycol	38779190301	G	$0.34	3	$1.28	$1.03	$1.03
Versapro Cream	38779252903	B	$3.20	45.02	$157.03	$144.06	$144.06
Fee	NA	NA	NA	NA	$15.00	$15.00	$15.00
						Total	$726.62

The total reimbursement is therefore $726.62. 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 $726.62.

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 $726.62, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	November 6, 2018 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.