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
TRUMBULL INSURANCE COMPANY

MFDR Tracking Number
M4-18-4766-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
August 6, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These medications do not require preauthorization therefore do not need a retrospective review."

Amount in Dispute: $583.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have requested a copy of the ESI EOB and will provide upon receipt."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 14, 2017	Pharmaceutical Compound	$583.89	$583.89

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 §124.2 sets out requirements for carrier reporting and notification.
3. 28 Texas Administrative Code §134.503 sets out the fee guideline for pharmacy services.
4. The insurance carrier denied payment based on the following claim adjustment codes:
   - P2 – Not a work related injury/illness and thus not the liability of the workers' compensation carrier.

Issues

1. Are there any outstanding issues of compensability, extent of injury or liability?
2. What is the recommended reimbursement for the disputed pharmaceutical compound?

Findings

1. The insurance carrier denied payment for the disputed compound with claim adjustment reason code P2 – "Not a work related injury/illness and thus not the liability of the workers' compensation carrier."

   The insurance carrier did not maintain this denial reason in the respondent's position statement.

Review of the submitted information finds no copies, as required by Rule §133.307(d)(2)(H), of any PLN-11 or plain language notices issued in accordance with Rule §124.2.

Rule §124.2(h) requires notification to the division and claimant of any dispute of disability or extent of injury using plain language notices with language and content prescribed by the division. Such notices "shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim."

Rule §133.307(d)(2)(H) further requires that If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with Rule §124.2 (relating to carrier reporting and notification requirements).

The insurance carrier's denial reason is not supported. Furthermore, because the respondent failed to meet the requirements of Rule §133.307(d)(2)(H) regarding notice of issues of liability, the respondent has waived the right to raise such issues during dispute resolution. Consequently, the division concludes there are no outstanding issues of compensability, extent of injury or liability for the injury.

2. This dispute regards a pharmaceutical compound with reimbursement subject to the *Pharmacy Fee Guideline*, 28 Texas Administrative Code §134.503(c), requiring 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)
FLURBIPROFEN	38779036209 Generic	$36.58	6	($36.58 × 6) × 1.25 = $274.35	$219.48	$219.48
MELOXICAM	38779274601 Generic	$194.67	0.2	($194.67 × 0.18) × 1.25 = $43.80	$35.04	$35.04
MEFENAMIC ACID	38779066906 Generic	$123.60	1.8	($123.60 × 1.8) × 1.25 = $278.10	$222.48	$222.48
BACLOFEN	38779038809 Generic	$35.63	3	($35.63 × 3) × 1.25 = $133.61	$106.89	$106.89
		Total Units:	10.98		Subtotal:	$583.89
					+ $15 compound fee = **Total**:	$598.89

   The total reimbursement for the medication in dispute is $598.89. The requestor is seeking $583.89. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

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.

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 $583.89.

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 $583.89, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	December 20, 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.

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.