



# 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**

Indemnity Insurance Co of North America

**MFDR Tracking Number**

M4-18-5183-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

August 24, 2018

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The above claimant received medication and the carrier still has not acknowledged receipt of service. Reimbursement should be made to the provider if the claim has been submitted within the 95<sup>th</sup> day after the date on which the health care service was rendered ... Memorial has attached both correspondences of proof requesting that the carrier provided an explanation of benefits or review."

**Amount in Dispute:** \$566.53

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Downs Stanford PC has been retained to represent the interest of the insurance carrier, Indemnity Insurance Company of North America, in the above referenced matter. The Carrier has submitted the medical bill in dispute for review, and payment is forthcoming."

**Response Submitted by:** Downs Stanford PC

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 14, 2018	Pharmacy services – Compound	\$566.53	\$566.53

#### 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 §133.240 sets out the procedure for medical bill processing by the workers' compensation insurance carrier.

3. 28 Texas Administrative Code §134.503 sets out the reimbursement for pharmacy services.
4. No explanation of benefits were found in the documentation.

### Issues

1. Did Indemnity Insurance Co of North America, reduce or deny the disputed services not later than the 45<sup>th</sup> day after receiving the medical bill?
2. Is the requestor entitled to additional reimbursement?

### Findings

This medical fee dispute was filed by health care provider Memorial Compounding Pharmacy on March 14, 2018. Memorial Compounding Pharmacy (Memorial) on its position asserts did not receive any correspondence as per rule so we submitted a Request for Reconsideration ... We have included documentation that we submitted original bill and then requested the carrier review bill again and we still did not get a response by Indemnity Insurance Co of North America for the compound it dispensed to a covered injured employee on March 14, 2018.

1. Memorial contends that Indemnity Insurance Co of North America “Bill for date of service 03/14/2018 still has not been processed by carrier. All bills are required to be processed within 45 days of receipts by the carrier.” Furthermore, in its reconsideration request, Memorial also alleges that “has not received any correspondence with explanation of review or benefits.”

According to Texas Labor Code Sec. 408.027 (b) Indemnity Insurance Co of North America was required to pay, reduce or deny the disputed services not later than the 45<sup>th</sup> day after it received the medical bill from Memorial. Corresponding 28 Texas Administrative Code §133.240 also required Indemnity Insurance Co of North America to take final action by issuing an explanation of benefits not later than the statutorily-required 45<sup>th</sup> day.

The following evidence supports that Indemnity Insurance Co of North America initially received the medical bill for the services in dispute on March 27, 2018.

- A copy of a certified mail receipt number 7014 2120 0004 2459 4498 addressed to Sedgwick.

Although there is evidence that Indemnity Insurance Co of North America received a medical bill for the service in dispute on March 27, 2018, Indemnity Insurance Co of North America failed to timely take the following actions:

Rule §133.240 (a) An insurance carrier **shall take final action** [emphasis added] after conducting bill review on a complete medical bill...**not later than the 45<sup>th</sup> day** [emphasis added] after the insurance carrier received a complete medical bill.”

Rule §133.240 (e) The insurance carrier **shall send the explanation of benefits** in accordance with the elements required by §133.500 and §133.501 of this title...The explanation of benefits shall be sent to:

- (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill...

The Division concludes that Indemnity Insurance Co of North America failure to timely issue an appropriate explanation of benefits creates a waiver of any new defenses presented in its response to medical fee dispute. Absent any evidence to the contrary, the Division finds that the services in dispute are eligible for payment.

2. Rule at 28 Texas Administrative Code §134.503 applies to the compound in dispute and states, in pertinent part:

(c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

- (1) the fee established by the following formulas 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:
  - (A) Generic drugs:  $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \$4.00$  dispensing fee per prescription = reimbursement amount;
  - (B) Brand name drugs:  $((\text{AWP per unit}) \times (\text{number of units}) \times 1.09) + \$4.00$  dispensing fee per prescription = reimbursement amount;
  - (C) When compounding, a single compounding fee of \$15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or
- (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
  - (A) health care provider; or
  - (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately as required by 28 Texas Administrative Code §134.502 (d)(2).

Each ingredient is listed below with its corresponding reimbursement amount as applicable.

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 HCL	38779237409	G	\$36.30	6	\$272.25	\$217.80	\$217.80
Cyclobenzaprine HCL	38779039509	G	\$46.33	1.8	\$104.25	\$83.39	\$83.39
Bupivacaine HCL	38779052405	G	\$45.60	1.2	\$68.40	\$54.72	\$54.72
						<b>Total</b>	<b>\$566.53</b>

The total reimbursement is therefore \$566.53. This amount is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$566.53.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$566.53, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Director for Medical Fee Dispute Resolution

\_\_\_\_\_  
11/16/2018  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 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 with the Division. **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.**