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
North River Insurance Company

MFDR Tracking Number
M4-18-5259-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
August 28, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim should be processed with the full amount billed as per **Administrative Labor Code 134.503 C**."

Amount in Dispute: $515.21

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Enclosed please find the EOB denying payment in this matter."

Response Submitted by: Hoffman Kelley Lopez, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 16, 2018	Compound Medication	$515.21	$515.21

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 (DWC).

Background

1. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical benefits.
4. Texas Labor Code §408.027 sets out the requirements for payment to the health care provider.
5. The documentation received by the DWC does not include explanations of benefits for the ingredients in question submitted prior to the date medical fee dispute resolution (MFDR) was requested.

Issues

1. Did the insurance carrier provide a payment, reduction, or denial to Memorial for the compound ingredients in question prior to the request for MFDR?
2. Is Memorial entitled to reimbursement for the disputed compound ingredients?

Findings

1. Memorial is seeking reimbursement for the following compound ingredients dispensed on February 16, 2018:

Drug	Quantity
Gabapentin USP	3.0 gm
Amitriptyline HCl	2.4 gm
Amantadine HCl	4.8 gm
Flurbiprofen	4.8 gm

Memorial contends that it did not receive payment from the insurance carrier regarding the billing for the ingredients in question. No explanations of benefits for these ingredients was included in the submitted documentation.

The insurance carrier was required to pay, reduce, or deny the disputed services not later than the 45th day after it received the medical bill from Memorial.[1] The greater weight of evidence supports that the insurance carrier received the medical bill for the ingredients in dispute on or about April 23, 2018.

Although there is evidence that the insurance carrier received a medical bill for the service in dispute on or about April 23, 2018, the insurance carrier failed to timely take final action and send the explanation of benefits to Memorial.[2]

The response from the insurance carrier is required to address only the denial reasons presented to the requestor prior to the request for MFDR was filed with the DWC. Any new denial reasons or defenses raised shall not be considered in this review.[3]

The submitted documentation does not support that any payment or denial for the disputed ingredients was provided to Memorial[4] before this request for MFDR was filed. Therefore, the DWC will not consider the arguments raised in its position statement in the current dispute review.

2. Because the insurance carrier failed to support any denial of payment, 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.[5] Each ingredient is listed below with its reimbursement amount.[6] The calculation of the total allowable amount is as follows:

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Gabapentin	38779246109	G	$59.85	3	$224.44	$179.55	$179.55
Amitriptyline	38779018904	G	$18.24	2.4	$54.72	$43.78	$43.78
Amantadine	38779041105	G	$24.23	4.8	$145.35	$116.30	$116.30
Flurbiprofen	38779036209	G	$36.58	4.8	$219.48	$175.58	$175.58
						Total	$515.21

[1] Texas Labor Code Sec. 408.027(b); 28 Texas Administrative Code §133.240(a)
[2] 28 Texas Administrative Code §133.240(a) and (e)
[3] 28 Texas Administrative Code §133.307(d)(2)(F)
[4] 28 Texas Administrative Code §133.240(a); Texas Labor Code §408.027(b)
[5] 28 Texas Administrative Code §134.502(d)(2)
[6] 28 Texas Administrative Code §134.503(c)

The total reimbursement is therefore $515.21. 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 $515.21.

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 $515.21, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	December 13, 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, 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.