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
New Hampshire Insurance Co

MFDR Tracking Number
M4-18-5319-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 30, 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 95th day after the date on which the health care service was rendered."

Amount in Dispute: $566.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In the absence of that information, a carrier cannot calculate the proper reimbursement or evaluate the medical necessity and appropriateness of a compound as prescribed and for the use indicated, or to evaluate fully and Quality of Care concern to rely to the Division and the FDA."

Response Submitted by: Flahive, Ogden & Latson

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 New Hampshire Insurance Co, reduce or deny the disputed services not later than the 45th 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 August 30, 2018

Memorial contends that New Hampshire Insurance Co failed to "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 as per Texas Labor Code 408.027(b)." Furthermore, in its reconsideration request, Memorial also alleges that "Pharmacy has not received any correspondence with explanation of review or benefits. An insurance carrier cannot extend or delay payment pending additional information in accordance with Rule 133.240(a)."

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

The following evidence supports that American Zurich Insurance Co initially received the medical bill for the services in dispute on March 27, 2017.

- A copy of a certified mail receipt dated March 27, 2017, number 7014 2120 0004 2459 4498 addressed to Sedgwick.

Although there is evidence that New Hampshire Insurance Co received a medical bill for the service in dispute on March 27, 2017, New Hampshire Insurance Co 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 45th 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…

28 Texas Administrative Code §133.307 (d)(2)(F) The [carrier's] 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.

The Division concludes that New Hampshire Insurance Co 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.

1. 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: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs: ((AWP per unit) x (number of units) x 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
						Total	$566.53

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	10/11/2018 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.