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
M4-19-0107-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
September 7, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Texas Labor Code Section 408.027 (b) requires that the carrier must pay, reduce, deny or determine to audit the health provider's claim no later than the 45th day after the date of receipt by the carrier."

Amount in Dispute: $569.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Enclosed please find the EOB issued after reconsideration of the bills presented denying payment in this matter."

Response Submitted by: Hoffman Kelley Lopez LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 14, 2018	Pharmaceutical Compound	$569.93	$569.93

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 provisions regarding medical payments and denials.
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:
   - P15 – Workers' Compensation Medical Treatment Guideline Adjustment.
   - A1 – Claim/Service denied.
   - @G(P15) No additional reimbursement allowed after review of appeal/reconsideration
   - HE83 – Duplicate Paid/Captured Claim

Issues

1. Are there any outstanding issues of medical necessity?
2. What is the recommended reimbursement for the disputed pharmaceutical compound?

Findings

1. The requestor is seeking reimbursement for a compounded medication dispensed on March 14, 2018.

   The insurance carrier denied payment for the disputed compound with claim adjustment code:

   - P15 – Workers' Compensation Medical Treatment Guideline Adjustment.

   Two of the explanations of benefits (EOB) submitted by the carrier indicate the carrier received the bill(s) on May 30, 2018; while one of the EOBs indicates the carrier received the bill(s) on May 21, 2018. The requestor provided a signed certified mail receipt showing the insurance carrier or their agent received the bill(s) on May 21, 2018. Based on the submitted information, the division finds the pharmacy bill(s) were received on May 21, 2018. The respondent's payment denial EOBs indicate audit dates of October 3, 2018 and October 4, 2018. These dates are later than the 45th day following carrier receipt of the disputed bill.

   The requestor submitted an EOB from the carrier, relating to Bupivacaine only, with a review date of June 6, 2018; however, the denial reason for that EOB indicates only HE83 – "Duplicate Paid/Captured Claim," and does not indicate denial due to adverse determination or any reason related to medical necessity or treatment guidelines.

   Rule §133.240(a) requires an insurance carrier to take final action after bill review not later than the 45th day after the date the insurance carrier received a complete medical bill. Rule §133.240(e)(2)(A) further requires carriers to send an EOB when denying payment due to an adverse determination. And Rule §133.307(d)(2)(B) requires respondents to provide to MFDR a paper copy of all EOBs related to the dispute.

   The respondent did not provide copies of any original EOBs that were the basis of the June 6th denial for "Duplicate Paid/Captured Claim," and thus the respondent failed to meet the requirements of Rule §133.307(d)(2)(B).

   The Peer Review and Plain Language Notice (PLN-11) submitted by the respondent are dated December 14, 2017 and December 18, 2017, both of which were issued before the date of service. Nor did the respondent support that either the PLN-11 or the Peer Review are related any of the denials on the EOBs.

   The Texas Supreme Court has held, based on Rule §133.240(a), "A carrier has up to forty-five days from the date it receives a complete medical bill to dispute whether that treatment was necessary." [1] Because the insurance carrier failed to dispute the medical necessity of the treatment within the time limit, the carrier has waived the right to dispute the necessity of that treatment altogether.

   Consequently, the division concludes there are no unresolved issues of medical necessity and the fee issues are eligible for review. The insurance carrier's denial reasons are not supported. The disputed compound will therefore be reviewed for payment in accordance with division rules and fee guidelines.

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.

[1] "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 *South Western Reporter Third* 646 (Texas 2009), http://www.search.txcourts.gov/historical/2009/aug/080363.pdf

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)
GABAPENTIN	38779246109 Generic	$59.85	3	($59.85 × 3) × 1.25 = $224.44	$179.55	$179.55
AMITRIPTYLINE HCL	38779018904 Generic	$18.24	2.4	($18.24 × 2.4) × 1.25 = $54.72	$43.78	$43.78
AMANTADINE HCL	38779041105 Generic	$24.23	4.8	($24.23 × 4.8) × 1.25 = $145.35	$116.30	$116.30
FLURBIPROFEN	38779036209 Generic	$36.58	4.8	($36.58 × 4.8) × 1.25 = $219.48	$175.58	$175.58
BUPIVACAINE HCL	38779052405 Generic	$45.60	1.2	($45.60 × 1.2) × 1.25 = $68.40	$54.72	$54.72
		Total Units:	16.2		Subtotal:	$569.93
					+ $15 compound fee = **Total**:	$584.93

The total reimbursement for the medication in dispute is $584.9. The requestor is seeking $569.93. 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 $569.93.

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 $569.93, 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 7, 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.