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
Zurich American Insurance Company

MFDR Tracking Number
M4-19-0115-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 7, 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: $726.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier understands the bill has been paid."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 14, 2018	Compound Medication	$726.62	$726.62

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 services.

Issues

Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the compound in question?

Findings

Memorial is seeking reimbursement for a compound dispensed on February 14, 2018. In its position statement, Flahive, Ogden & Latson argued on behalf of the insurance carrier that the bill has been paid. The DWC reviewed the submitted documents.

Memorial submitted a document April 26, 2018, labeled "REMITTANCE ADVICE," as evidence of non-payment. This document indicates that the review agent recommended payment of $343.22 and then reversed that payment in the same document. No codes were provided to support a denial of payment for the compound in dispute.

The insurance carrier submitted a document dated September 17, 2018, labeled "Transaction Details" as evidence of payment. However, this document was for a different date of service.

Based on the documentation provided, the DWC finds that there is insufficient evidence that the insurance carrier reimbursed the compound in question or provided a reason for denial as required by 28 TAC §133.240(f).

Because the insurance carrier failed to sufficiently support its denial of reimbursement or that the bill had been paid, 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.[1] Each ingredient is listed below with its reimbursement amount.[2] 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
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	38779237409	G	$36.30	6	$272.25	$217.80	$217.80
Cyclobenzaprine	38779039509	G	$46.33	1.8	$104.24	$83.39	$83.39
Bupivacaine	38779052405	G	$45.60	1.2	$68.40	$54.72	$54.72
Ethoxy Diglycol	38779190301	G	$0.34	3	$1.28	$1.03	$1.03
Versapro Cream	38779252903	B	$3.20	45.02	$157.03	$144.06	$144.06
Fee	NA	NA	NA	NA	$15.00	$15.00	$15.00
						Total	$726.62

The total reimbursement is therefore $726.62. This amount is recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $726.62.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services.
The DWC hereby ORDERS the respondent to remit to the requestor $726.62, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

[1] 28 TAC §134.502(d)(2)
[2] 28 TAC §134.503(c)

Authorized Signature

	Laurie Garnes	September 19, 2019
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.