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
HARTFORD ACCIDENT & INDEMNITY COMPANY

MFDR Tracking Number
M4-19-0236-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
September 17, 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: $798.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "There is no support for the two compounded topical medications."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 14, 2018	Pharmaceutical Compound	$798.06	$798.06

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 §124.2 sets out requirements for carrier reporting and notification.
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:
   - P2 -Not a work related injury/illness and thus not the liability of the workers' compensation carrier.

Issues

1. Are there unresolved issues regarding liability for the injury?
2. Did the respondent raise new denial reasons or defenses in their position statement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied payment for the disputed compound with claim adjustment reason code P2 – "Not a work related injury/illness and thus not the liability of the workers' compensation carrier."

   The insurance carrier did not maintain this denial reason in the respondent's position statement.

   Review of the submitted information finds no copies, as required by Rule $133.307(d)(2)(H), of any PLN-11 or plain language notices issued in accordance with Rule §124.2.

   Rule §124.2(h) requires notification to the division and claimant of any dispute of disability or extent of injury using plain language notices with language and content prescribed by the division. Such notices "shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim."

   Rule §133.307(d)(2)(H) further requires that If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with Rule §124.2 (relating to carrier reporting and notification requirements).

   The insurance carrier's denial reason is therefore not supported. Furthermore, because the respondent failed to meet the requirements of Rule §133.307(d)(2)(H) regarding notice of issues of liability, the respondent has waived the right to raise such issues during dispute resolution. Consequently, the division concludes there are no outstanding issues of compensability or liability for the injury.

2. Review of the insurance carrier's response finds new denial reasons or defenses raised that were not presented to the requestor before the filing of the request for medical fee dispute resolution.

   Rule §133.307(d)(2)(B) requires that upon receipt of the request for medical fee dispute resolution, the respondent shall provide any missing information not provided by the requestor and known to the respondent, including:

   > a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider . . . related to the health care in dispute not submitted by the requestor or a statement certifying that the respondent did not receive the health care provider's disputed billing prior to the dispute request.

   Review of the submitted information finds no documentation to support any EOBs were presented to the health care provider giving notice of the new denial reasons or defenses raised in the insurance carrier's response to MFDR.

   Rule §133.307(d)(2)(F) requires that:

   > The 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.

   Pursuant to Rule §133.307(d)(2)(F), the insurance carrier's failure to give notice to the health care provider of specific codes or explanations for reduction or denial of payment as required by Rule §133.240 constitutes grounds for the division to find a waiver of defenses during Medical Fee Dispute Resolution.

   Upon review of the insurance carrier response, the division finds the respondent has raised new denial reasons or defenses of which the carrier failed to give any notice to the health care provider during the bill review process or before the filing of this dispute. Consequently, the division concludes the insurance carrier has waived the right to raise such new denial reasons or defenses during dispute resolution. Any such new defenses or denial reasons will not be considered in this review.

3. 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.

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)
FLURBIPROFEN	38779036209 Generic	$36.58	6	($36.58 × 6) × 1.25 = $274.35	$219.48	$219.48
MELOXICAM	38779274601 Generic	$194.67	0.2	($194.67 × 0.18) × 1.25 = $43.80	$35.04	$35.04
MEFENAMIC ACID	38779066906 Generic	$123.60	1.8	($123.60 × 1.8) × 1.25 = $278.10	$222.48	$222.48
BACLOFEN	38779038809 Generic	$35.63	3	($35.63 × 3) × 1.25 = $133.61	$106.89	$106.89
BUPIVACAINE HCL	38779052405 Generic	$45.60	1.2	($45.60 × 1.2) × 1.25 = $68.40	$54.72	$54.72
ETHOXY DIGLYCOL	38779190301 Generic	$0.34	3	($0.34 × 3) × 1.25 = $1.28	$1.03	$1.03
VERSAPRO	38779252903 *Brand*	$3.20	45	($3.20 × 44.82) × 1.09 = $156.33	$143.42	$143.42
		Total Units:	60		Subtotal:	$783.06
					+ $15 compound fee = **Total**:	$798.06

The total reimbursement for the medication in dispute is $798.06. 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 $798.06.

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 $798.06, 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 20, 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.