



# 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**

TPCIGA for Lumbermens Mutual Casualty Company

**MFDR Tracking Number**

M4-19-0240-01

**Carrier's Austin Representative**

Box Number 50

**MFDR Date Received**

September 17, 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:** \$583.89

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "These services were sent for Retrospective Utilization Review and determined to be outside of the ODG (Official Disability Guidelines) and therefore not medically necessary."

**Response Submitted by:** Texas Property & Casualty Insurance Guaranty Association

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 14, 2018	Compound Medication	\$583.89	\$583.89

#### 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 §133.240 sets out the procedures for payment or denial of a medical bill.
2. 28 Texas Administrative Code §133.305 sets out the procedures for resolving medical disputes.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
5. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
6. 28 Texas Administrative Code, Chapter 19 sets out the requirements for utilization review.
7. The insurance carrier reduced payment for the disputed services based on medical necessity.

## Issues

1. Is this dispute subject to dismissal based on medical necessity?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the disputed compound?

## Findings

1. Memorial is seeking reimbursement for a compound dispensed on March 14, 2018. The insurance carrier denied the compound based on medical necessity.

Per submitted explanation of benefits dated May 30, 2018, the pharmacy bill was originally received by the insurance carrier on March 22, 2018. The process date is more than 45 days after the date the complete bill was received.<sup>1</sup>

The insurance carrier has the obligation to dispute whether a treatment was medically necessary within 45 days after receiving a complete medical bill.<sup>2</sup> The Texas Department of Insurance, Division of Workers' Compensation (DWC) notes that the insurance carrier failed to present evidence of a denial for medical necessity within 45 days from the date it received the complete pharmacy bill. Therefore, the DWC finds that the dispute in question is not subject to dismissal based on medical necessity.

2. Because the insurance carrier failed to support its denial of reimbursement, Memorial is entitled to reimbursement in accordance with applicable rules and laws.

The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately.<sup>3</sup> Each ingredient is listed below with its reimbursement amount.<sup>4</sup> 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
Flurbiprofen	38779036209	G	\$36.58	6	\$274.35	\$219.48	\$219.48
Meloxicam	38779274601	G	\$194.67	0.18	\$43.80	\$35.04	\$35.04
Mefenamic Acid	38779066906	G	\$123.60	1.8	\$278.10	\$222.48	\$222.48
Baclofen	38779038809	G	\$35.63	3	\$133.61	\$106.89	\$106.89
						Total	\$583.89

The total allowable reimbursement for the compound in dispute is \$583.89. This amount is recommended.

## Conclusion

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 \$583.89.

## **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 division hereby ORDERS the respondent to remit to the requestor \$583.89, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

<sup>1</sup> 28 Texas Administrative Code §133.240(a)

<sup>2</sup> "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 S.W.3d 646 (Tex. 2009), <https://caselaw.findlaw.com/tx-supreme-court/1388209.html>

<sup>3</sup> 28 Texas Administrative Code §134.502(d)(2)

<sup>4</sup> 28 Texas Administrative Code §134.503(c)

**Authorized Signature**

\_\_\_\_\_  
Signature

Laurie Garnes  
\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

November 6, 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 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.**