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
New Hampshire Insurance Company

MFDR Tracking Number
M4-19-0431-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 27, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027."

Amount in Dispute: $916.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Memorial should send its bill directly to the PBM … In this case, Memorial dropped the bill to paper and sent directly to the Carrier."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 27, 2018	Cyclobenzaprine 10 mg tablets	$155.78	$126.85
April 27, 2018	Gabapentin 300 mg capsules	$177.26	$153.70
April 27, 2018	Compound Medication	$583.89	$583.89
	Total	$916.93	$864.44

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 §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
4. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical benefits.
5. Texas Labor Code §408.027 sets out the requirements for payment to the health care provider.

6. The submitted documentation does not include explanations of benefits.

Issues

1. Did the insurance carrier provide a payment, reduction, or denial to Memorial Compounding Pharmacy (Memorial) prior to the request for medical fee dispute resolution (MFDR)?
2. Is Memorial entitled to reimbursement for the services in dispute?

Findings

1. Memorial is seeking reimbursement for Cyclobenzaprine 10 mg tablets, Gabapentin 300 mg capsules, and a compound that were dispensed on April 27, 2018. Flahive, Ogden & Latson argued that "Memorial should send its bill directly to the PBM … In this case, Memorial dropped the bill to paper and sent directly to the Carrier."

   Documentation received in this dispute by the Texas Department of Insurance, Division of Workers' Compensation (DWC) finds that Memorial submitted the bill in question to Sedgwick. Information available to the DWC finds that Sedgwick is an agent of New Hampshire Insurance Company, the insurance carrier in this dispute.

   The evidence submitted in this dispute is not sufficient to support that a payment, reduction, or denial was provided to Memorial[1] prior to its request for medical fee dispute resolution.

2. Because the insurance carrier failed to support any denial of payment, Memorial is entitled to reimbursement.

   The reimbursement for the drugs considered in this dispute is calculated as follows[2]:

   - Cyclobenzaprine 10 mg tablets: (1.092 x 90 x 1.25) + $4.00 = $126.85
   - Gabapentin 300 mg capsules: (1.3307 x 90 x 1.25) + $4.00 = $153.70

   The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately.[3] Each ingredient is listed below with its reimbursement amount.[4] 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 reimbursement is therefore $864.44. This amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been 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 $864.44.

[1] 28 Texas Administrative Code §133.240; Texas Labor Code §408.027
[2] 28 Texas Administrative Code §134.503(c)
[3] 28 Texas Administrative Code §134.502(d)(2)
[4] 28 Texas Administrative Code §134.503(c)

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 $864.44, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	November 19, 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, 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.