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 RX

Respondent Name
PA Manufacturers Assn Ins Co

MFDR Tracking Number
M4-19-0547-01

Carrier's Austin Representative Box
BOX 19

Fee Dispute Request Received
October 1, 2018

Response Submitted by:
Gallagher Bassett Services

REQUESTOR POSITION SUMMARY

"The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027."

RESPONDENT POSITION SUMMARY

"No claim on record for the named patient"

SUMMARY OF REQUEST AND DIVISION ORDER

Disputed Date of Service	Disputed Service	Disputed Amount	Division Order
April 26, 2018	Medications	$293.11	$222.75

AUTHORITY

Texas Labor Code §413.031 (c). In resolving disputes over the amount of payment due for medically necessary services for treatment of the compensable injury, the role of the medical fee dispute resolution program is to adjudicate the payment given the relevant statutory provisions and commissioner rules.

Background

1. 28 Texas Administrative Code §133.2 defines a complete medical bill.
2. 28 Texas Administrative Code §133.10 sets out the minimum requirements for a complete medical bill.
3. 28 Texas Administrative Code §124.1 sets out the carrier's duty to provide written notice of injury to the division.
4. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmacy services.
5. No evidence of an EOB.
6. Rejection Letters from Gallagher Bassett dated July 12, 2018:
   The above referenced billing for medical related services has been received in our Clinton Medical Bill Processing Center. This billing cannot processed for payment consideration because of the following reason(s):

   No claim on record for the named patient

   To further consider the billing for payment, please send: A COPY OF THE BILL ALONG WITH THE REQUESTED INFORMATION, OR DOCUMENTATION. PLEASE ALSO BE CERTAIN THAT THE INJURED EMPLOYEE'S SOCIAL SECURITY NUMBER AND DATE OF INJURY ARE NOTED ON THE BILLING.

Findings

The provider, MEMORIAL COMPOUNDING RX, presented evidence sufficient to support that it requested payment from PA Manufacturers Assn Ins Co [carrier] for medications provided to a covered injured employee. The carrier did not pay, reduce, or deny the complete medical bill in 45 days. Instead, the carrier rejected the billing citing that there was no claim on record. MEMORIAL asked for reconsideration and requested an EOB as required.[1] The provider then filed for medical fee dispute resolution (MFDR).

1. *Did the carrier timely pay, reduce or deny the services in dispute?*

It is the duty of the workers' compensation insurance carrier or an agent acting on the carrier's behalf to pay, reduce, or deny a complete medical bill within 45 days from the date of receipt. The carrier's rejection letter states, in part, that the medical bill could not be processed because it was incomplete. A complete medical bill is defined at §133.2(4) which states that a complete medical bill is one that contains all required fields specified in §133.10. The instructions for a complete pharmacy bill are located in paragraph (f)(3) of §133.10.

The evidence provided by the parties prove that the pharmacy bill submitted by Memorial to the carrier meets the definition of a complete medical bill; and that both the original and reconsideration pharmacy bill contained a social security number and a date of injury. The carrier's rejection reason is unsupported.

Furthermore, the carrier reasoned that it could not process the bill because it could not locate "a claim for the patient." Rule at §124.1 states that the carrier is obligated to report an injury/establish a claim if it receives a communication – regardless of the source - which fairly informs the carrier of the name of the injured employee, the identity of the employer, the approximate date of the injury and information which asserts the injury is work related. The pharmacy bill provided to the carrier included all the information to compel the carrier to establish a claim and report the injury to the DWC. This reason for rejection of the medical bill in dispute is also unsupported.

The insurance carrier failed to timely pay, reduce or deny a complete medical bill. The carrier also failed to take final action[2] by issuing an explanation of benefits (EOB) in the form and manner required by 28 TAC §133.240.[3]

Absent any evidence that PA Manufacturers Assn Ins Co or an agent acting on PA Manufacturers Assn Ins Co's behalf timely presented any defenses to the provider that conform with the requirements of Title 28, Part 2, Chapter 133, Subchapter C, the Division finds that the medications are eligible for reimbursement.

2. *What is the total reimbursement for the service in dispute?*

Rule 28 Texas Administrative Code §134.503 applies to the reimbursement for medications.[4] The listing of the medications in dispute is found on the medical bill.[5]

The calculation of the total allowable amount is as follows:

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed / Tablets	AWP Formula	Billed Amt	Lesser of AWP and Billed
Cyclobenzaprine	65162054150	G	$1.09	30	$40.88	$90.26	$40.88
Meloxicam	29300012510	G	$4.85	30	$181.88	$202.85	$181.88
						Total	$222.75

The total reimbursement is therefore $222.75. This amount is recommended.

[1] 28 Texas Administrative Code §133.250

[2] 28 Texas Administrative Code §133.2 (6) Final action on a medical bill-- (A) sending a payment…(B) denying a charge on the complete medical bill.

[3] 28 Texas Administrative Code §133.240 (e) The insurance carrier shall send an explanation of benefits

[4] 28 Texas Administrative Code §134.503

[5] 28 Texas Administrative Code §134.502 (d)(2)

Decision

For the reasons above, the division finds that reimbursement is due. As a result, the amount ordered is $222.75.

DIVISION ORDER

The division has determined that the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $222.75, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		March 15, 2019
Signature	Medical Fee Dispute Resolution Director	Date

RIGHT TO APPEAL

Either party to this medical fee dispute may seek review of this division decision. To appeal, submit form division Form-045M titled ***Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)*** found at https://www.tdi.texas.gov/forms/form20numeric.html.

Follow the instructions on pages 3 and 4. The request must be received by the division within twenty days of your receipt of this decision. This decision becomes final if the request for review of this decision is not submitted within twenty days.

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.

If you have questions about the division Form-045M, please call CompConnection at 1-800-252-7031, Option 3 or you may email your question to CompConnection@tdi.texas.gov

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, Option 1.