



# 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**

Sentinel Insurance Company, Ltd.

**MFDR Tracking Number**

M4-19-0707-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

October 9, 2018

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "As of today, we still haven't received this check or a proper explanation of denial."

**Amount in Dispute:** \$726.62

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Denial of the compounded medication in dispute was based on the following findings:

- MMI reached on 9/30/17
- There are no office visit notes that address the use of the compounded medication.
- Info letter was sent to the prescribing physician.

Compounded medication in dispute is not supported under current evidenced-based treatment recommendations."

**Response Submitted by:** The Hartford

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 20, 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.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the fee schedule for pharmaceutical services.

## Issues

1. Did the insurance carrier raise a new defense in its response?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the compound in question?

## Findings

1. Memorial is seeking reimbursement for a compound dispensed on January 20, 2018. In its position statement, The Hartford, on behalf of the insurance carrier, argued that the compound medication was disputed based on an MMI reached September 30, 2017, no office notes to address the compound medication, and no supporting evidence.

The response from the insurance carrier is required to address only the denial reasons presented to the requestor the request for medical fee dispute resolution (MFDR) was filed with the Texas Department of Insurance, Division of Workers' Compensation (DWC). Any new denial reasons or defenses raised shall not be considered in this review.<sup>1</sup>

The submitted documentation does not support that a denial based on issues raised by The Hartford were provided to Memorial before this request for MFDR was filed. Therefore, the DWC will not consider this argument in the current dispute review.

2. Because the insurance carrier failed to support its denial of reimbursement, Memorial is entitled to reimbursement for the compound listed above.

The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately.<sup>2</sup> Each ingredient is listed below with its reimbursement amount.<sup>3</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
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. The insurance carrier processed the bill and reimbursed \$0.00. A reimbursement of \$726.62 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 \$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.

<sup>1</sup> 28 Texas Administrative Code §133.307(d)(2)(F)

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

<sup>3</sup> 28 Texas Administrative Code §134.503(c)

**Authorized Signature**

\_\_\_\_\_  
Signature

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

August 16, 2019  
\_\_\_\_\_  
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.**