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
Zurich American Insurance Company

MFDR Tracking Number
M4-19-1212-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 2, 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: "The issue of medical necessity has been joined, and the disputed services have not yet been determined to be medically necessary and appropriate … The Requestor did not request and receive the preauthorization for this investigational or experimental compound formulation, or for this compound that is not included in Division's Closed Formulary … 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
March 15, 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 (DWC).

Background

1. 28 Texas Administrative Code §133.10 sets out the requirements for completing medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

Issues

1. Did the insurance carrier raise a new defense in its response?
2. Is the insurance carrier's denial of payment based on billing errors supported?
3. Is Memorial Compounding Rx entitled to reimbursement for the compound in question?

Findings

1. Memorial is seeking reimbursement for a compound dispensed on March 15, 2018. In its position statement, Flahive, Ogden & Latson, on behalf of the insurance carrier, argued that an unresolved medical necessity dispute exists for this request, the health care provider did not request preauthorization, and that network rules apply to this service.

   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.[1]

   The submitted documentation does not support that denial reasons based on issues above were provided to Memorial before this request for MFDR was filed. Therefore, the DWC will not consider these arguments in the current dispute review.

2. Zurich American Insurance Company denied the compound based on billing errors. The documentation submitted does not support the insurance carrier's denial of payment for this reason.

3. Because the insurance carrier failed to sufficiently support its denial of reimbursement, Memorial is entitled to reimbursement.

   The compound in dispute was billed by listing each **drug** included in the compound and calculating the charge for each drug separately.[2] Each ingredient is listed below with its reimbursement amount.[3] 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. 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 $726.62.

[1] 28 TAC §133.307 (d)(2)(F)
[2] 28 Texas Administrative Code §134.502(d)(2)
[3] 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 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.

Authorized Signature

	Laurie Garnes	February 12, 2020
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 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.