



# 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**

Property & Casualty Insurance Company of Hartford

**MFDR Tracking Number**

M4-19-1478-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

November 15, 2018

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The NDC number provided is a valid NDC number and claim should be processed accordingly."

**Amount in Dispute:** \$798.06

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "This services is not supported ... There was no evidence of an updated comprehensive physical examination conducted in recent weeks or months ... Based on this lack of information, the current request is not medically necessary."

**Response Submitted by:** The Hartford

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 12, 2018	Compound Medication	\$798.06	\$798.06

### 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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.210 sets out the documentation requirements for bill submission.
- 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 21 – Missing/invalid NDC number
  - N26 – 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 carrier's denial based on NDC number supported?
3. Is the carrier's denial based on submission or billing errors supported?
4. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the compound in question?

## Findings

1. In its position statement, The Hartford, on behalf of the insurance carrier, argued that "Based on this lack of information, the current request is not medically necessary."

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.

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

2. Memorial is seeking reimbursement for a compound dispensed on April 12, 2018. The insurance carrier denied reimbursement, in part, based on a missing or invalid NDC number. No evidence was presented to support that Memorial submitted a bill including a missing or invalid NDC number for the ingredients in question. This denial reason is not supported.
3. The insurance carrier also denied reimbursement based on submission or billing errors. Review of the documentation submitted does not support this denial reason.
4. 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.<sup>1</sup> Each ingredient is listed below with its reimbursement amount.<sup>2</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
Bupivacaine	38779052405	G	\$45.60	1.2	\$68.40	\$54.72	\$54.72
Ethoxy Diglycol	38779052405	G	\$0.34	3	\$1.28	\$1.03	\$1.03
Versapro Cream	38779252903	B	\$3.20	44.82	\$156.33	\$143.42	\$143.42
Fee	NA	NA	NA	NA	\$15.00	\$15.00	\$15.00
						Total	\$798.06

The total reimbursement is therefore \$798.06. 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 \$798.06.

<sup>1</sup> 28 Texas Administrative Code §134.502(d)(2)

<sup>2</sup> 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 \$798.06, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

\_\_\_\_\_  
Signature

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

\_\_\_\_\_  
August 26, 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.**