



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

NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number

M4-19-1539-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

November 15, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial did not receive any correspondence as per rule so we submitted a Request for Reconsideration. ... and we still did not get a response."

Amount in Dispute: \$726.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent raises new denial reasons or defenses in their position statement that were not presented to the requestor prior to the filing of this request for medical fee dispute resolution. Pursuant to Rule §133.307(d)(2)(F), any new denial reasons or defenses raised shall not be considered in this review.

Response Submitted by: Flahive, Odgen & Latson, Attorneys at Law, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 28, 2018	Pharmaceutical Compound	\$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 procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.500 defines words and terms relating to pharmaceutical benefits.
3. 28 Texas Administrative Code §134.503 sets out the fee guideline for pharmacy services.
4. 28 Texas Administrative Code §134.530 sets out closed formulary requirements for non-network claims.
5. 28 Texas Administrative Code §133.2 defines terms related to medical billing and processing.
6. 28 Texas Administrative Code §133.230 sets out requirements for insurance carrier audit of medical bills.
7. 28 Texas Administrative Code §133.240 sets out procedures for medical bill payments and denials.
8. 28 Texas Administrative Code §133.250 sets out procedures for reconsideration of payment for medical bills.
9. 28 Texas Administrative Code §133.500 establishes standards and formats for electronic medical bill processing.
10. 28 Texas Administrative Code §133.501 sets out requirements for electronic medical bill processing.
11. Texas Labor Code §408.027 sets out requirements regarding payment of health care providers.

12. Neither party to this dispute presented copies of explanations of benefits for review.
13. No evidence was presented to support the carrier took final action on the medical bill(s) or issued any notice of adjustment reason codes or explanation for payment denial, as required by Rule §§ 133.240(e) and (f).
14. This decision is based on the information available at the time of review, pursuant to Rule §133.307(d)(1).

Issues

1. Has the insurance carrier waved the right to raise any denial reasons or defenses to payment?
2. What is the recommended reimbursement for the disputed pharmaceutical compound?

Findings

1. The requestor states they did not receive any correspondence from the insurance carrier in response to their billing or request for reconsideration of the disputed pharmacy billing.

Rule §133.307(d)(2) requires the respondent to provide with their response any missing information not provided by the requestor and known to the respondent.

Rule §133.307(d)(2)(B) further requires the respondent to provide copies of all EOBs related to the health care in dispute (as originally submitted to the provider in accordance with 28 Texas Administrative Code Chapter 133) that were not submitted by the requestor. In the alternative, the respondent shall provide a statement certifying the respondent did not receive the health care provider's disputed billing prior to the dispute request.

The carrier response did not include any explanations of benefits as originally submitted to the provider in accordance with Chapter 133. Nor did the respondent provide a statement certifying the respondent did not receive the health care provider's disputed billing prior to this dispute request.

Rule §133.307(d)(1) provides that if the division does not receive the required response information within 14 calendar days of dispute notification, then the division may base its decision on the available information.

Accordingly, this decision is based on the information presented by the parties available at the time of review.

Texas Labor Code Sec. 408.027(b), requires that:

The insurance carrier must pay, reduce, deny, or determine to audit the health care provider's claim not later than the 45th day after the date of receipt by the carrier of the provider's claim.

Corresponding Rule §133.240(a) requires that:

An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

Final action on a medical bill is defined in 28 Texas Administrative Code §133.2(6) as:

- (A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement . . . and/or
- (B) denying a charge on the medical bill.

Rule §133.240(e) requires the insurance carrier to send to the health care provider an explanation of benefits in accordance with elements described in 28 Texas Administrative Code §133.500 and §133.501 whenever the carrier pays or denies a bill.

Rule §§ 133.240(f)(17)(G) and (H) further require the paper form of an explanation of benefits under Rules §133.240(e) and §133.250 (relating to reconsideration) to include, for each billed health care service, an *adjustment reason code* conforming to standards described in Rules §133.500 and §133.501 as well as an *explanation* of the reason for reduction or denial, if applicable.

Review of the submitted information finds a facsimile (fax) transmission cover sheet and signed certified mail return receipts to support timely carrier receipt of the pharmacy's initial billing and request for reconsideration.

However, no evidence was found to support the carrier took final action after conducting bill review on the medical bills or determined to audit the bills in accordance with Rule §133.230 before the 45th day following receipt of the bills. Accordingly, the division concludes the insurance carrier failed to meet the requirements of Labor Code §408.027(b) and Rule §§ 133.240(a), (e) and (f).

All workers' compensation insurance carriers are expected to fulfill their duty to take final action as required by law and the division's administrative rules. The insurance carrier failed to do so in this case.

Rule §133.307(d)(2)(F) requires that:

The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

The insurance carrier's failure to issue explanations of benefits to the health care provider constitutes grounds for the division to find a waiver of defenses at Medical Fee Dispute Resolution.

No evidence was presented to support the carrier provided notice to the provider, in the form and format required by division rules, of any denial reasons or defenses regarding the pharmacy bills in question prior to the filing of the MFDR request. Consequently, the division concludes the respondent has waived such defenses.

Any newly raised denial reasons or defenses shall not be considered in this review.

Because the carrier did not take final action on the medical bills or give notice of any adjustment reason codes or explanations for denial. And because the carrier has waived all defenses, the disputed pharmacy services will be reviewed for payment in accordance with division rules and fee guidelines.

2. This dispute regards a pharmaceutical compound with reimbursement subject to the *Pharmacy Fee Guideline*, 28 Texas Administrative Code §134.503(c), requiring the insurance carrier to reimburse prescription drugs the lesser of: (1) the fee established by formula in the rule based on the average wholesale price (AWP) as reported by nationally recognized pharmaceutical pricing data; or (2) the amount billed.

Reimbursement is calculated as follows:

Ingredient(s)	NDC & Type	Unit Price	Total Units	AWP Formula §134.503(c)(1)	Billed Amount §134.503(c)(2)	Lesser of (c)(1) or (c)(2)
MELOXICAM	38779274601 Generic	\$194.67	0.2	$(\$194.67 \times 0.18) \times 1.25 = \43.80	\$35.04	\$35.04
FLURBIPROFEN	38779036209 Generic	\$36.58	4.8	$(\$36.58 \times 4.8) \times 1.25 = \219.48	\$175.58	\$175.58
TRAMADOL HCL	38779237409 Generic	\$36.30	6	$(\$36.30 \times 6) \times 1.25 = \272.25	\$217.80	\$217.80
CYCLOBENZAPRINE HCL	38779039509 Generic	\$46.33	1.8	$(\$46.33 \times 1.8) \times 1.25 = \104.25	\$83.39	\$83.39
BUPIVACAINE HCL	38779052405 Generic	\$45.60	1.2	$(\$45.60 \times 1.2) \times 1.25 = \68.40	\$54.72	\$54.72
ETHOXY DIGLYCOL	38779190301 Generic	\$0.34	3	$(\$0.34 \times 3) \times 1.25 = \1.28	\$1.03	\$1.03
VERSAPRO	38779252903 *Brand*	\$3.20	45	$(\$3.20 \times 45.02) \times 1.09 = \157.03	\$144.06	\$144.06
Total Units:			62	Subtotal:		\$711.62
+ \$15 compound fee = Total:						\$726.62

The total reimbursement for the medication in dispute is \$726.62. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was 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 \$726.62.

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 \$726.62, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

<p>_____</p>	<p>Grayson Richardson</p>	<p>December 14, 2018</p>
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.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form DWCO45M) in accordance with the form’s instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.