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
State Office of Risk Management

MFDR Tracking Number
M4-19-3610-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
March 27, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial Compounding Pharmacy has met the requirements to receive reimbursement."

Amount in Dispute: $333.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In review of the dispute packet the requestor has failed to submit documentation to substantiate the prescriptions nor medical documentation from the prescribing physician supporting how the medications are related to the compensable injury. Further review of this claim file, the injured employee has not been seen by his treating doctor since 4/4/2018."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 19, 2018	Cyclobenzaprine 10 mg Tablets	$155.78	$126.85
October 19, 2018	Gabapentin 300 mg Capsules	$177.26	$153.70
	Total	$333.04	$280.55

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 §133.210 sets out the documentation requirements for bill submission.
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:
   - 16/6553 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
   - Note: "There is no medical documentation to substantiate this prescription"
   - W3 – Additional payment made on appeal/reconsideration.

Issues

1. Is Texas Mutual Insurance Company's denial of payment supported?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the disputed drugs?

Findings

1. Memorial is seeking reimbursement for drugs dispensed on October 19, 2018. State Office of Risk Management denied the drugs, in part, based on "submission/billing error(s)." Review of the submitted pharmacy bills finds no submission or billing errors.[1] The insurance carrier failed to support this denial in its position statement.

   In its position statement, State Office of Risk Management argued that this denial reason was used because "the requestor failed to submit documentation to substantiate the prescriptions nor medical documentation from the prescribing physician supporting how the medications are related to the compensable injury."

   Because a denial based on relatedness to the compensable injury was not presented to Memorial prior to the date the request for medical fee dispute resolution was filed[2], the DWC will only review the insurance carrier's argument that the denial was based on documentation.

   Documentation requirements for medical bills are established by 28 Texas Administrative Code §133.210, which does not require documentation to be submitted with pharmaceutical services.

   When documentation is not required, an insurance carrier may request additional documentation to process a medical bill. To request additional documentation, the insurance carrier is required to submit the request to the health care provider. The request shall:

   - be in writing;
   - be specific to the bill or the bill's related episode of care;
   - describe with specificity the clinical and other information to be included in the response;
   - be relevant and necessary for the resolution of the bill;
   - be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
   - indicate the specific reason for which the insurance carrier is requesting the information; and
   - include a copy of the medical bill for which the insurance carrier is requesting the additional documentation.[3]

   No documentation was found to support that State Office of Risk Management made an appropriate request for additional documentation with the require specificity. Therefore, State Office of Risk Management's denial for this reason is not supported.

2. Because the insurance carrier failed to support its denial of payment for the disputed drugs, Memorial is entitled to reimbursement.

   The reimbursement considered in this dispute is calculated as follows[4]:

   - Cyclobenzaprine HCl 10 mg tablets: (1.092 x 90 x 1.25) + $4.00 = $126.85

[1] 28 Texas Administrative Code §133.10(f)(3)
[2] 28 Texas Administrative Code §133.307(d)(2)(F)
[3] 28 Texas Administrative Code §133.210(d)
[4] 28 Texas Administrative Code §134.503(c)

- Gabapentin 300 mg capsules: (1.3296 x 90 x 1.25) + $4.00 = $153.70

The total reimbursement is therefore $280.55. 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 $280.55.

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 $280.55, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	August 29, 2019
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.