



# 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**

North River Insurance Co

**MFDR Tracking Number**

M4-18-4975-01

**Carrier's Austin Representative**

Box Number 53

**MFDR Date Received**

August 15, 2018

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The above claimant received medication and the carrier still has not acknowledged receipt of service. Reimbursement should be made to the provider if the claim has been submitted within the 95<sup>th</sup> day after the date on which the health care service was rendered."

**Amount in Dispute:** \$569.93

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Enclosed please find the EOB denying payment in this matter. Also enclosed are a PLN-11 dated 12-18-2017 disputing the extent of injury, and the peer review authored by Robert Holladay, M.D. dated 12-14-2017 which explains why these medications are not reasonable or necessary to treat the injured worker for her compensable injury."

**Response Submitted by:** Hoffman Kelley Lopez LLP

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 30, 2018	Pharmacy Services	\$569.93	\$569.93

### 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 §134.502 sets out the procedures for pharmaceutical benefits.
- 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:
  - HE70 – Product/service not covered

- HEC7 – Reduction applied in accordance with carrier contract rate per state guidelines

## Issues

1. Is North River Insurance Co's reason for denial of payment supported?
2. Did North River Insurance Co raise a new defense pursuant to 28 Texas Administrative Code §133.307?
3. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the compound in question?

## Findings

1. Memorial is seeking reimbursement of \$569.93 for a compound dispensed on January 30, 2018. North River Insurance Co denied the disputed compound with claim adjustment reason code HE70 – “Product/service not covered” and HEC7 – “Reduction applied in accordance with carrier contract rate per state guidelines.” Review of the submitted documentation failed to support that either Memorial Compounding Pharmacy or the listed prescriber is not a covered provider. For this reason, the division finds that this denial reason is not supported.
2. In its position statement, Hoffman Kelley Lopez LLP argued on behalf of North River Insurance Co, “Enclosed please find the EOB denying payment in this matter. Also enclosed are a PLN-11 dated 12-18-2017 disputing the extent of injury, and the peer review authored by Robert Holladay, M.D. dated 12-14-2017 which explains why these medications are not reasonable or necessary to treat the injured worker for her compensable injury.”

28 Texas Administrative Code §133.307(d)(2)(F) states, in relevant part, “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.”

Review of the submitted documentation finds that North River Insurance Co failed to present a extent of injury denial to Memorial in accordance with 28 Texas Administrative Code §133.240 prior to the date the request for medical fee dispute resolution (MFDR) was filed. The division concludes that this defense presented in Hoffman Kelley Lopez LLP's position statement shall not be considered for review because this assertion constitutes a new defense pursuant to 28 Texas Administrative Code §133.307(d)(2)(F).

3. 28 Texas Administrative Code §134.503 applies to the compounds in dispute and states, in pertinent part:
  - (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
    - (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
      - (A) Generic drugs:  $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.25) + \$4.00$  dispensing fee per prescription = reimbursement amount;
      - (B) Brand name drugs:  $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.09) + \$4.00$  dispensing fee per prescription = reimbursement amount;
      - (C) When compounding, a single compounding fee of \$15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or
    - (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
      - (A) health care provider; or
      - (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately as required by 28 Texas Administrative Code §134.502(d)(2). Each ingredient is listed below with its corresponding reimbursement amount as applicable.

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Amantadine HCL	38779041105	G	\$24.23	4.8	\$145.35	\$116.30	\$116.30
Flurbiprofen	38779036209	G	\$36.58	4.8	\$219.48	\$175.58	\$175.58
Gabapentin	38779246109	G	\$59.85	3	\$224.44	\$179.55	\$179.55
Amitriptyline HCL	38779018904	G	\$18.24	2.4	\$54.72	\$43.78	\$43.78
Bupivacaine HCL	38779052405	G	\$45.60	1.2	\$68.40	\$54.72	\$54.72
						Total	\$569.93

The total reimbursement is therefore \$569.93. This amount is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$569.93.

### **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 \$569.93, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

### **Authorized Signature**

		10/4/2018
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 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 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.**