



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

Zurich American Insurance Co

MFDR Tracking Number

M4-18-5312-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

August 30, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Texas Labor Code Section 408.027 (b) requires that the carrier must pay, reduce, deny or determine to audit the health provider's claim no later than the 45th day after the date of receipt by the carrier. Memorial did not receive any correspondence as per rule..."

Amount in Dispute: \$726.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Medical Necessity Dispute is unresolved."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 29, 2016	Compounded Pharmacy Services	\$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 the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.240 sets out requirements of sending explanation of benefits.
3. 28 Texas Administrative Code §134.503 sets out pharmacy fee guidelines.
4. Neither party submitted an explanation of benefits in this dispute.

Issues

1. Did the insurance carrier comply with DWC rules?
2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking \$726.62 for a compounded medication dispensed on March 29, 2018. The respondent states in their position, "The Medical Necessity Dispute is unresolved."

Review of the submitted documentation found insufficient evidence to support the insurance carrier complied with requirements of 28 TAC §133.240 (e) which states,

The insurance carrier shall send the explanation of benefits in accordance with the elements required by §133.500 and §133.501 of this title (relating to Electronic Formats for Electronic Medical Bill Processing and Electronic Medical Bill Processing, respectively) if the insurance carrier submits the explanation of benefits in the form of an electronic remittance. The insurance carrier shall send an explanation of benefits in accordance with subsection (f) of this section if the insurance carrier submits the explanation of benefits in paper form. The explanation of benefits shall be sent to:

- (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill;

Based on the above, the respondent's position will not be considered in this review. The services in dispute will be reviewed per applicable fee guidelines.

2. 28 TAC 134.503 (c) states in pertinent part,

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: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;

- (B) Brand name drugs: $((\text{AWP 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;

The calculation of the fee is as follows:

Ingredient	NDC	Price/ Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Meloxicam	38779274601	\$194.67	0.18	\$43.80	\$35.04	\$35.04
Flurbiprofen	38779036209	\$36.58	4.8	\$219.48	\$175.58	\$175.58
Tramadol	38779237409	\$36.30	6	\$272.25	\$217.80	\$217.80
Cyclobenzaprine	38779039509	\$46.33	1.8	\$104.25	\$83.39	\$83.39
Bupivacaine	38779052405	\$45.60	1.2	\$68.40	\$54.72	\$54.72
Ethoxy Diglycol	38779190301	\$0.34	3	\$1.28	\$1.03	\$1.03
Versapro Cream	38779252903	\$3.20	45.02	\$157.03	\$144.06	\$144.06
Compounding fee	NA	\$15.00	1	NA	\$15.00	\$15.00
					Total	\$726.62

Conclusion

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

Signature	Medical Fee Dispute Resolution Officer	October 10, 2018 Date
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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.