TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Memorial Compounding Pharmacy

**Respondent Name**
New Hampshire Insurance Co

**MFDR Tracking Number**
M4-18-0426-01

**Carrier's Austin Representative**
Box 19

**MFDR Date Received**
October 18, 2017

## *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:** $131.30

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "After reviewing this dispute, the Carrier reimbursed the Provider $9.01. Payment was issued on 10/6/17, check number 32421625. Attached for your consideration is a copy of the "Explanation of Benefits" and payment history."

**Response Submitted by:** AIG

## *SUMMARY OF FINDINGS*

| Date of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| May 4, 2017 | Tylenol Tab | $131.30 | $0.00 |

## *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 §134.503 sets out the reimbursement for medications
3. Explanation of Benefits:
   Issued October 6, 2017
   - 1 – The charge for the over-the-counter medication exceeds the retail price

**Findings**

The Division makes the following conclusions based upon the information and documentation presented to the Division to date. Even though all the evidence was not discussed, it was considered.

*1. Did the carrier reimburse Memorial for the disputed services?*

Memorial Compounding Rx (Memorial) asserts that the carrier has not paid for the service in dispute. Review of the explanations of benefits provided finds that the carrier issued a payment in the amount of $9.01 to Memorial on October 6, 2017 via check number 32421625.

The Division concludes that Memorial has received payment for the service in dispute before the filing of this medical fee dispute.

*2. Is additional reimbursement due?*

The carrier reduced the billed amount to a total payment of $9.01 citing "the charge for the over-the-counter medication exceed the retail price" as its reason for the reduction. Rule at 28 Texas Administrative Code §134.503(c) applies and states, in pertinent part, that the insurance carrier shall reimburse the lesser of: (1) the fee established by the Division's applicable formula 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; or (2) the amount billed to the insurance carrier.

Memorial is requesting reimbursement in the amount of $131.30 for the disputed service. Memorial has the burden to support its request for this amount. In its original position statement, Memorial did not demonstrate how it arrived at the requested amount or whether that amount is consistent with the methodology under 28 TAC §134.503(c). After notification by the Division's medical fee dispute resolution program of the carrier's response and payment, Memorial did not take the opportunity to refute the carrier's payment calculation. For that reason, the Division moves to resolve this dispute with the information available and concludes that no additional reimbursement can be recommended.

**Conclusion**

The Division concludes that Memorial has already been paid for the service in dispute. As a result, the amount ordered is $0.00.

## *ORDER*

Based on the submitted information, and pursuant to Texas Labor Code Section 413.031, the division has determined that the requestor is not entitled to additional reimbursement for the services in dispute.

**Authorized Signature**

| | | April 20, 2018 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 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 with the Division. **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**.