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**
Texas Mutual Insurance Co

**MFDR Tracking Number**
M4-18-0588-01

**Carrier's Austin Representative**
Box 54

**MFDR Date Received**
November 3, 2017

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The Texas Labor Code Section 408.027(b) requires that the carrier must pay, reduce, or deny or determine to audit the health care 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:** $333.07

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "In order to resolve this fee reimbursement dispute Texas Mutual Insurance Company has elected to pay the disputed services."

**Response Submitted by:** Texas Mutual Insurance Co

## *SUMMARY OF FINDINGS*

| Date of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| May 23, 2017 | Prescription Medications | $333.07 | $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:
   - P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.

**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 make a payment for the disputed services?*

Memorial Compounding Rx (Memorial) asserts that it did not receive a response from the carrier up to the date that it filed this medical fee dispute. In its position, Memorial references Texas Labor Code Sec. 408.027 (b). This provision obligates the carrier to take final action by paying, reducing or denying the disputed services and issuing an explanation of benefits within 45 days after it has received the complete medical bill. The carrier in this case did not refute Memorial's assertion; however the carrier did decide to issue a payment for the service in dispute shortly after they were notified of this matter.

The carrier made a payment to Memorial in the amount of $149.66 on December 5, 2017 via check number 01639661.

The Division concludes that the carrier issued payment for the disputed service after Memorial filed this medical fee dispute.

*2. Is additional reimbursement due?*

The carrier reduced the billed amount to a total payment of $149.66 citing the workers' compensation fee schedule 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 $333.07 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. After Memorial was notified by the Division's medical fee dispute resolution program of the carrier's response and payment, it 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 failed to support its request for additional reimbursement. 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**

| | | |
|---|---|---|
| | | March 23, 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**.