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
Hartford Insurance Company of Midwest

MFDR Tracking Number
M4-18-0745-01

Carrier's Austin Representative
Box 47

MFDR Date Received
November 17, 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 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: $90.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our investigation shows the following: Provider submitted billing for cyclobenzaprine HCL, 10mg, 30 days supply. Payment issued in the amount of $4.38 on 05/27/17. Confirmed with Express Scripts that payment issued to the provider is correct based on their contract with them."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
May 8, 2017	Prescription Medication	$90.26	$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:
    - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement

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.

Documentation supports the carrier made a payment to Memorial in the amount of $4.38 on May 27, 2017 via remit id 456722. Memorial's assertion that it did not receive a response from the carrier is therefore unsupported.

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

2. Is additional reimbursement due?

The carrier reduced the billed amount to a total payment of $4.38. Rule at 28 Texas Administrative Code §134.503 applies and states that the insurance carrier shall reimburse: (1) the lesser of the fee established by the Division's applicable (AWP) formula or the amount billed to the insurance carrier under §134.503(c); or (2) at a contract rate that complies with the provisions of Labor Code §408.0281 and applicable §134.503(f).

Memorial is requesting reimbursement in the amount of $90.26 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 reduction reasons as stated on the explanation of benefits. 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

		February 22, 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.