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 RX

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-18-0942-01

Carrier's Austin Representative
Box 15

MFDR Date Received
December 06, 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: $298.29

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has issued payment for the dates of service listed on the Table of Disputed Services. Please see the attached EOB which documents the payment was made on 11/27/17 via EFT."

Response Submitted by: Downs Stanford Pc

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
July 12, 2017	Prescription Medications	$298.29	$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 compound medications
3. Explanation of Benefits:
   - P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.

- 4282 – Drugs identified with a status of "Y" in the current edition of the "Official Disability Guidelines Treatment in Workers' Comp" (ODG)/ Appendix A, "ODG Workers' Compensation Drug Formulary" identify A drugs that can be dispensed without preauthorization. The allowance has been determined in according to the pharmacy fee guidelines.

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 any correspondence 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.

Review of the explanation of benefits and position statement provided by the carrier finds:

- that the carrier received the bill for the disputed services on September 25, 2017;
- that an explanation of benefits was issued on November 27, 2017 to Memorial Compounding Pharmacy;
- that a payment in the amount of $169.24 was issued on to Memorial November 27, 2017; and
- that the payment was made via electronic funds transfer number 76967935.

The carrier issued the payment and an explanation of benefits within the timeframes specified by TLC 408.027(b), Memorial's assertion that it did not receive any correspondence is unsupported.

The Division concludes that the carrier made a timely payment to Memorial for the disputed services prior to the filing of this medical fee dispute.

2. Is additional reimbursement due?

The carrier reduced the billed amount to a total payment of $169.24 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 has requested reimbursement in the amount of $298.29. 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 disputed amount. After Memorial was notified by the Division's medical fee dispute resolution program of the carrier's response, it did not take the opportunity to refute the carrier's payment calculation or the carrier's explanation of payment. For those reasons, 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

		January 26, 2018
Signature	Medical Fee Dispute Resolution Director	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.