



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Memorial Compounding Pharmacy

Respondent Name

Valley Forge Insurance Co

MFDR Tracking Number

M4-18-1013-01

Carrier's Austin Representative

Box 57

MFDR Date Received

December 8, 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: \$63.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...the Carrier respectfully requests an order of no additional reimbursement due as Memorial Compounding RX was paid by First Script pursuant to the contacted [sic] rate in compliance with the Texas Labor Code and the Administrative Rules. Carrier has requested information from First Script regarding proof of payment to Memorial Compound in accord with the explanation of review recommending payment in the amount of \$4.80."

Response Submitted by: Brian J. Judis

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
April 24, 2017	Prescription Medication	\$63.19	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes
- 28 Texas Administrative Code §134.503 sets out the reimbursement for compound medications

3. Explanation of Benefits:

Issued May 17, 2017

- 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issued May 25, 2017

- 18 – Exact duplicate claim/service

Issued June 1, 2017

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

Issued August 17, 2017

- 18 – Exact duplicate claim/service.
- W3 – Request for reconsideration.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issued October 17, 2017

- 23 – The impact of prior payer(s) adjudication including payments and/or adjustments.
- W3 – Request for reconsideration.
- 193 – Original payment decision is being maintained.

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 \$4.80 to Memorial on June 1, 2017 via check number 105568782.

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 \$4.80 citing the charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement 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 \$63.19 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 18, 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.