



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 RX

Respondent Name

AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number

M4-18-1026-01

Carrier's Austin Representative

Box 19

MFDR Date Received

December 11, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Bill was processed and payment recommended in the amount of \$136.40...we still haven't received the payment from the carrier."

Amount in Dispute: \$272.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill has been paid in the amount of \$136.40 per the attached EOB...The Requestor's representative should consult with pharmacy accounting staff and confirm this payment. A copy of the bulk check is attached."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
April 7, 2017	Prescription Medications	\$272.02	\$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.
 - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

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 medications in dispute?

Memorial Compounding Rx (Memorial) asserts that it received an explanation of benefits allowing for payment, however it did not receive the indicated payment from the carrier up to the date that it filed this medical fee dispute.

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

- that the carrier initially received the bill for the disputed services on April 18, 2017;
- that an initial explanation of benefits was issued on May 3, 2017 to Memorial Compounding Pharmacy; and
- that a payment in the amount of \$136.40 was issued to Memorial on June 5, 2017, check number 0002048859.

The carrier issued the EOB and payment for the service in dispute. Memorial's assertion that it did not receive payment is unsupported.

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

2. Is additional reimbursement due for ibuprofen?

The carrier reduced the billed amount to a total payment of \$136.40 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 \$272.02. 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. 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

Signature

Medical Fee Dispute Resolution Director

January 30, 2018
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.