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
Texas Municipal League Intergovernmental

MFDR Tracking Number
M4-18-1219-01

Carrier's Austin Representative
Box 19

MFDR Date Received
January 4, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the original bill as well and the reconsideration based on Extent of Injury."

Amount in Dispute: $457.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor initially submitted this bill electronically to its PBM. After providing the requested Letter of Medical Necessity, the bill was paid by OPTUM/TMESYS by check number 2061621, issued on 07/18/2017 accompanied by an electronic remittance advice. The bulk check was in the amount of $25,966.85, which was paid on 07/27/2017. The PBM has been reimbursed by the Self-Insured per its contract with the PBM. The Self-Insured understands the payment amount for this date of service was $363.00." …The Requestor's boilerplate letters submitted with the DWC-60 claim the Self-Insured has denied the bill on extent of injury. No such denial exists. The Self-Insured did separately issue EOBs denying the right to payment. The first denial was pending receipt of a Letter of Medical Necessity (as this script was outside the patient's drug regimen). Upon reconsideration, the bill was denied as it has already been paid through the electronic PBM process."

Response Submitted by: Flahive, Ogden and Latson

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
June 5, 2017	Prescription Medication	$457.50	$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:
   Issued June 30, 2017
   - 16 – Please submit letter of medical necessity from prescribing doctor

   Issued November 11, 2107
   - 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 information provided finds that the carrier issued a payment in the amount of $363.00 to Memorial on July 27, 2017 by check number 2061621.

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 $363.00. 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 $457.50 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 20, 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.