



## 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**

TASB Risk Management Fund

**MFDR Tracking Number**

M4-18-1824-01

**Carrier's Austin Representative**

Box 47

**MFDR Date Received**

February 2, 2018

### ***REQUESTOR'S POSITION SUMMARY***

**Requestor's Position Summary:** "The carrier denied the original bill as well, and the reconsideration based on Partial Payment."

**Amount in Dispute:** \$129.07

### ***RESPONDENT'S POSITION SUMMARY***

**Respondent's Position Summary:** "TASB-RMF received the original bill on 6/24/17 and processed the bill for reimbursement in the amount of \$93.46."

**Response Submitted by:** TASB Risk Management Fund

### ***SUMMARY OF FINDINGS***

Date of Service	Disputed Services	Amount In Dispute	Amount Due
June 23, 2017	Prescription Medication	\$129.07	\$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 29, 2017

- Bill processed/reimbursed on EOMB #2889639

Issued November 29, 2017

- 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 make a payment for the disputed services?*

Memorial Compounding Rx (Memorial) asserts that it received several denials for the services in dispute.

Documentation supports the carrier made a payment to Memorial in the amount of \$93.46 on June 28, 2017 via check number 6230691. 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 \$93.46. 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 \$129.07 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**

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Signature

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Medical Fee Dispute Resolution Officer

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April 6, 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.**