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
New Hampshire Insurance Co

MFDR Tracking Number
M4-18-2104-01

Carrier's Austin Representative
Box 19

MFDR Date Received
February 16, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…Memorial Compounding Pharmacy has met the requirements to receive reimbursement."

Amount in Dispute: $185.41

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier's EOB is attached."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
June 13, 2017	Prescription Medication	$185.41	$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 medications.
3. Explanation of Benefits:
   - P12 – The charge for the over-the-counter medication exceeds the retail price

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?

Documentation supports the carrier made a payment to Memorial in the amount of $96.02 on July 28, 2017.

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 $96.02. 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 $185.41 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

		March 23, 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.