



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

North River Insurance Company

MFDR Tracking Number

M4-18-2498-01

Carrier's Austin Representative

Box Number 53

MFDR Date Received

March 12, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The original bill was submitted to carrier (**VIA CERTIFIED MAIL ON 09/29/2017**) ... Memorial did not receive any correspondence as per rule so we submitted Request for Reconsideration ... The request was submitted and received by the carrier on **11/17/2017** still with no response."

Amount in Dispute: \$726.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Enclosed please find the EOB dated April 9, 2018 recommending payment in the amount of \$567.30, which has now been paid by the Carrier."

Response Submitted by: Hoffman Kelley Lopez, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 21, 2017	Pharmacy Service – Compound	\$726.32	\$15.00

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 fee guidelines for pharmaceutical services.
3. The documentation submitted to the division does not include explanations of benefits presented to the requestor prior to the request for medical fee dispute resolution.

Issues

Is Memorial Compounding Pharmacy (Memorial) entitled to additional reimbursement for the compound in question?

Findings

Memorial is seeking reimbursement for a compound dispensed on September 21, 2017. The insurance carrier reduced the billed amount to a total payment of \$567.30, citing the workers’ compensation fee schedule as its reason for the reduction. 28 TAC §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 the burden to support its requested amount. In its 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. The division concludes that Memorial failed to support the billed amount sought for the compound ingredients in question. For this reason, no additional reimbursement is recommended for the compound ingredients.

28 Texas Administrative Code §134.503(c)(1)(C) states that when compounding, a single compounding fee of \$15.00 per prescription shall be added to the calculated total calculation for compounds. Review of the submitted documentation finds that North River Insurance Company failed to reimburse the compounding fee of \$15.00 in its subsequent payment to Memorial. Therefore, the division finds that an additional reimbursement of \$15.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$15.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$15.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Laurie Garnes

Medical Fee Dispute Resolution Officer

May 14, 2018

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *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. **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.