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 COMPANY

MFDR Tracking Number
M4-19-0090-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 7, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "we submitted the original bill and then requested the carrier review bill again and we still did not get a response."

Amount in Dispute: $798.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment om the amount of $798.06 was mailed to Memorial's mailing address"

Response Submitted by: Flahive, Odgen & Latson, Attorneys at Law, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 29, 2018	Pharmacy Services	$798.06	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 guideline for pharmacy services.
3. No explanations of benefits for the disputed pharmacy services were presented for review.

Findings

Based on the information presented to MFDR by the parties up to the date of review, the division makes the following findings. Even though not all the evidence was discussed, it was considered.

Is additional reimbursement due?

Memorial Compounding Pharmacy (Memorial) asserts the insurance carrier has not paid for the services in dispute. The respondent presented documentation to support that the insurance carrier issued payment of $798.06 by check to the requestor mailed on October 31, 2018.

Rule §134.503(c) requires the insurance carrier to reimburse prescription drugs the lesser of: (1) the fee established by formula in the rule based on the average wholesale price (AWP) as reported by nationally recognized pharmaceutical pricing data; or (2) the amount billed.

Memorial requests reimbursement of $798.06 for the disputed services. The respondent submitted documentation to support payment of $798.06 to Memorial, leaving remaining balance due of $0.00.

The division notified Memorial of the carrier's payment and asked the requestor to respond with any additional information pertaining to this dispute. To date, Memorial has not responded. The requestor has the burden at MFDR to support its position that additional reimbursement is due.

Based on the information available at the time of review, additional reimbursement cannot be recommended.

Conclusion

The division concludes that the requestor has already been paid for the service in dispute. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	March 1, 2019
Signature	Medical Fee Dispute Resolution Officer	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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.