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
American Zurich Insurance Company

MFDR Tracking Number
M4-19-0744-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 11, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As of today we still haven't received this check or a proper explanation of denial."

Amount in Dispute: $726.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… the Carrier understands the bill was eventually paid…"

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 16, 2018	Compound Medication	$726.62	$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

28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

Issues

Is the requestor entitled to additional reimbursement?

Findings

Review of the explanations of benefits provided finds that the carrier initially denied payment due to submission or billing errors. Upon reconsideration, the carrier did not maintain its original denial and issued a payment to

Memorial on September 10, 2018. The DWC concludes that Memorial has received payment for the service in dispute.

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 DWC'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 $726.62 for the disputed compound. 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 DWC's medical fee dispute resolution program of the insurance carrier's response and payment, Memorial did not take the opportunity to refute the insurance carrier's payment calculation. For that reason, the DWC moves to resolve this dispute with the information available and concludes that no additional reimbursement can be recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

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

Authorized Signature

	Laurie Garnes	August 29, 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, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.