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
XL SPECIALTY INSURANCE CO

MFDR Tracking Number
M4-19-0748-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 11, 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: $1,065.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "we have asked that our pharmacy benefit manager process this for payment."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 30, 2018	Pharmacy Services	$1,065.56	$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. The insurance carrier denied payment based on the following claim adjustment codes:
   - F – Payment reduced: In accordance with DWC fee guidelines.
   - 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor. This change effective 11/1/2012

Findings

Are there any unresolved issues of compensability or liability for the disputed services?

The insurance carrier originally denied the disputed services with reason code 109 – "Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor. This change effective 11/1/2012." However, the payer did not maintain this denial reason after reconsideration. The division thus concludes that there are no unresolved issues of liability. This dispute is thus eligible for review in accordance with division rules.

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 the insurance carrier issued payment of $1,030.96 to Memorial in November 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 $1,065.56 for the disputed services. The respondent submitted documentation to support payment of $1,0360.96 to Memorial, asserting that the carrier applied "the AWP value using Medispan prising including the 4% rollback that occurred in September 2009 in the AWP of certain drugs."

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 findings in this decision are based on the information available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division concludes the requestor has been paid for the services in dispute. Additional reimbursement is not supported. 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	April 18, 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.