



# 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**

Trumbull Insurance Company

**MFDR Tracking Number**

M4-19-0986-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

October 19, 2018

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The above patient was prescribed medication and the carrier received and processed the bill. Carrier denied the claim and the provider submitted a request for reconsideration. The request for reconsideration in accordance with Rule 133.250 was submitted to the carrier but claim was processed and denied again."

**Amount in Dispute:** \$702.68

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Retro Review performed 03/13/18 & 03/15/18."

**Response Submitted by:** The Hartford

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 26, 2018	Compound Medication	\$702.68	\$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 fee guidelines for pharmaceutical services.

**Issues**

Is Memorial Compounding Pharmacy (Memorial) entitled to additional reimbursement?

**Findings**

Review of the submitted remittance advice, the insurance carrier issued a payment to Memorial on March 27, 2018, via check number 3067159. The division concludes that Memorial has received payment for the drug in dispute.

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 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 is requesting reimbursement in the amount of \$702.68 for the disputed drugs. 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 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. For that reason, the division moves to resolve this dispute with the information available and concludes that no additional reimbursement can be recommended.

**Conclusion**

For the reasons stated above, the Division 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 division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

	Laurie Garnes	April 11, 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 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.**