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
Travelers Indemnity Co

MFDR Tracking Number
M4-19-0993-02

Carrier's Austin Representative
Box Number 5

MFDR Date Received
January 14, 2019

Response Submitted By:
Travelers

REQUESTOR'S POSITION SUMMARY

"The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027."

RESPONDENT

"The Carrier has reviewed the claim and determined the Provider is entitled to reimbursement. The Carrier is issuing reimbursement for the disputed services in accordance with the…adopted fee schedule."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 30, 2018	Cyclobenzaprine 10 mg Tablets	$155.78	$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 process for medical fee dispute resolution
2. 28 Texas Administrative Codes §134.503 sets out the reimbursement for pharmacy services

Findings

The Division makes the following conclusions based upon the information and documentation presented to the Division to date. Even though all the evidence was not discussed, it was considered.

1. Did the carrier reimburse Memorial for the disputed services?

Memorial Compounding Rx (Memorial) asserts that the carrier has not paid for the service in dispute. Review of the explanations of benefits provided finds that the carrier originally issued a payment in the amount of $126.85 to Memorial on May 18, 2018, check numbered 681525. The Division concludes that Memorial has received payment for the service in dispute.

2. Is additional reimbursement due?

The carrier reduced the billed amount to a total payment of $126.85 citing the workers' compensation fee schedule. 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 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 additional reimbursement in the amount of $155.78 for the disputed service. 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).

On July 26, 2019, the Division's medical fee dispute resolution program provided a copy of the carrier's payment evidence to Memorial. Memorial did not take the opportunity to refute the carrier's payment. For that reason, the division makes its decision based on the information available and concludes that no additional reimbursement can be recommended.

Conclusion

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

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, and 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

		August 5, 2019
Signature	Medical Fee Dispute Resolution Director	Date

RIGHT TO APPEAL

Either party to this medical fee dispute may seek review of this division decision. To appeal, submit form division Form-045M titled ***Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)*** found at https://www.tdi.texas.gov/forms/form20numeric.html.

Follow the instructions on pages 3 and 4. The request must be received by the division within twenty days of your receipt of this decision. This decision becomes final if the request for review of this decision is not timely made.

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.

If you have questions about the division Form-045M, please call CompConnection at 1-800-252-7031, Option 3 or you may email your question to CompConnection@tdi.texas.gov