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
SOUTHERN VANGUARD

MFDR Tracking Number
M4-19-1476-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
November 15, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These medications do not require preauthorization therefore do not need a retrospective review."

Amount in Dispute: $524.22

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the Provider was paid $373.53 for the date of service 4/10/18. The check was issued on 10/12/18."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 10, 2018	Pharmacy Services	$524.22	$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:
   - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE
   - C45 – DENIED: PER CARRIER, PRE-AUTHORIZATION NOT REQUESTED.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.

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 carrier has not paid for the services in dispute. Review of the submitted explanations of benefits (EOBs) finds the carrier initially denied payment for the disputed services with claim adjustment reason code:

- C45 – DENIED: PER CARRIER, PRE-AUTHORIZATION NOT REQUESTED.

However, upon reconsideration, the carrier did not maintain its original denial reasons, issuing payment of $373.53 to Memorial by check dated October 15, 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 $524.22 for the disputed services. The insurance carrier supported payment of $373.53. The requestor has the burden at MFDR to support its position that additional reimbursement is due. In its position statement, Memorial did not explain or demonstrate how it arrived at the requested reimbursement amount or whether that payment is consistent with the methodology listed in Rule §134.503(c).

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.

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

Conclusion

The division concludes that the requestor has been paid the amount due 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 8, 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.