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
OLD REPUBLIC INSURANCE COMPANY

MFDR Tracking Number
M4-19-1766-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
November 28, 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: $726.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment has been made on 12/18/18 with check number 2201378."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
July 12, 2018	Pharmacy Services	$726.62	$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:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies

Findings

Is additional reimbursement due?

The requestor asks for reimbursement of $726.62 for the disputed services.

After the filing of this medical fee dispute request, the respondent presented documentation to support the insurance carrier issued payment of $611.36, by check (check number 2201378), to Memorial Compounding Pharmacy on or about December 18, 2018.

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 replied. Accordingly, the decision and findings in this dispute are based on the information available at the time of review.

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.

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 concludes Memorial failed to support that additional payment is due. Consequently, additional reimbursement is not recommended.

Conclusion

The division concludes that the requestor has been paid for the pharmacy services 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 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.

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.