



# 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**

United Airlines, Inc.

**MFDR Tracking Number**

M4-19-1964-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

December 6, 2018

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "It looks like the carrier processed and paid only PARTIAL of the total bill ... After reviewing the explanation of benefits it indicates that carrier paid **\$99.58** and not the full amount of **\$555.68.**"

**Amount in Dispute:** \$450.16

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The Self-Insured understands this bill is covered by Memorial's PBM and that it has been reviewed in accordance with Memorial's PBM contract ... The Requestor has not shown itself entitled to payment."

**Response Submitted by:** Flahive, Ogden & Latson

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 14, 2018	Compound Medication	\$450.16	\$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 (DWC).

**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 pharmacy payments.

**Issues**

Is the requestor entitled to additional reimbursement?

**Findings**

Review of the explanations of benefits provided finds that the carrier issued a payment in the amount of \$99.58 to Memorial on or about June 22, 2018 via check number 71632809. The DWC concludes that Memorial has received payment for the compound in dispute.

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 DWC’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 \$450.16 for the disputed compound. 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 DWC’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 DWC 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 DWC 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 DWC hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

	Laurie Garnes	January 9, 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.**