



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

MEMORIAL COMPOUNDING PHARMACY

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number

M4-19-1982-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

December 6, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim should be processed with the full amount billed as per Administrative Labor Code 134.503 C."

Amount in Dispute: \$583.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual Insurance Company has elected to pay the disputed services."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 14, 2018	Pharmacy Services	\$583.89	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.503 sets out the fee guideline for pharmacy services.
- The insurance carrier denied payment based on the following claim adjustment codes:
 - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
 - 872 – RULE 134.502 REQUIRES COMPOUND DRUGS BE BILLED BY LISTING EACH DRUG INCLUDED AND CALCULATING THE CHARGE FOR EACH DRUG SEPARATELY.
 - 920 – REIMBURSEMENT IS BEING ALLOWED BASED UPON A DISPUTE.

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.

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

Memorial Compounding Pharmacy (Memorial) asserts the insurance carrier has not paid for the services in dispute. Review of the submitted explanations of benefits (EOB) finds the carrier initially denied payment for lack of preauthorization. Upon reconsideration, the carrier did not maintain its denial, issuing payment of \$583.89.

2. *Is additional reimbursement due?*

The carrier reduced payment for the disputed services to a total of \$583.39, indicating claim adjustment code P12 – “WORKERS’ COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT” as the reason for reduction.

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 submitted evidence supports that Memorial received the payment.

The division further 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 is not recommended.

Conclusion

The division concludes that the requestor has already been paid 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

Signature

Grayson Richardson
Medical Fee Dispute Resolution Officer

January 18, 2019
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 DWCO45M) 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.