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
K MART CORP

MFDR Tracking Number
M4-19-2349-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
December 21, 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: $702.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "There are three medications in which Requestor did not submit a pharmacy bill… Requestor has paid for the 7 medication in which a pharmacy bill was received."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
August 14, 2018	Pharmacy Services	$1,156.22	$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:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 3 – CHARGE FOR PHARMACEUTICALS EXCEED THE FEES ESTABLISHED BY THE FEE SCHEDULE.
   - 91 – DISPENSING FEE ADJUSTMENT.
   - 1 – A DISPENSING FEE IS NOT APPLICABLE TO THE ALLOWANCE OR PAYMENT OF THE MEDICATION.

Findings

Did the pharmacy submit bills for all the medications in dispute?

The respondent asserts: "There are three medications in which Requestor did not submit a pharmacy bill…"

Review of the MFDR request form DWC060 *Table of Disputed Services* finds three items listed (Ethoxy Diglycol, Versapro Cream, and "compounding fee") for which no medical bills were provided by the requestor.

Rule §133.307(c)(2)(J) requires the Health Care Provider to submit with their request for MFDR:

> a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions)

Based on the information submitted for review, Ethoxy Diglycol and Versapro Cream are disputed items that were not supported as having been billed to the insurance carrier. Nor was any information presented to support that any of the disputed items were compounded together.

The division concludes the requestor failed to support the request for additional reimbursement for Ethoxy Diglycol, Versapro Cream, and compounding fee. Accordingly, payment for these items is not recommended.

Is additional reimbursement due?

The insurance carrier provided documentation to support that an electronic funds transfer of $1,065.13 was issued to the provider in payment of the disputed pharmacy services on January 4, 2019. The carrier reduced payment for the disputed items using claim adjustment code P12 – "Workers' compensation jurisdictional fee schedule adjustment."

The division's medical fee dispute resolution program notified Memorial of the carrier's response and payment; however, after notification, the pharmacy did not provide additional information to refute the carrier's payment calculation or to support their request for additional reimbursement.

The division's *Pharmacy Fee Guideline*, 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 requested reimbursement of $1,156.22 for the disputed medications. Memorial has the burden to support the request for payment. Their position statement did not explain how they calculated the amount due or whether that amount is consistent with the fee established by the division's formula in Rule §134.503.

Based on the information available at the time of review, the requestor's position is not supported. Consequently, additional reimbursement cannot be recommended.

Conclusion

The division concludes the requestor has 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

	Grayson Richardson	February 22, 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.