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
XL SPECIALTY INSURANCE COMPANY

MFDR Tracking Number
M4-19-3573-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 25, 2019

Response Submitted By
Broadspire

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."

RESPONDENT'S POSITION SUMMARY

"Payment has been recommended for $279.03. We are attaching the EOB."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 15, 2018	Pharmacy Services	$711.16	$0.00

AUTHORITY

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 as set out in Title 28, Part 2 of the Texas Administrative Code.

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.
   - D3 – The charge for the prescription drug is greater than the maximum reimbursement for a generic drug.
   - E1 – The provider does not appear to have a valid Drug Enforcement Agency (DEA) ID on file. As the service rendered is a drug item classified by the DEA as a federally controlled substance, it is recommended the provider submit an updated DEA ID in order to remain compliant.
   - E3 – The provider dispensed a drug item classified by the Drug Enforcement Agency (DEA) as a federally controlled substance with a DEA Class of CI, CII, or CV. The Controlled Substances Act monitors these classes of drugs due to the high abuse potential.
   - HE75 – Prior Authorization required to process this bill.

Issue

Is additional reimbursement due?

Findings

Memorial Compounding Pharmacy (Memorial) asserts the insurance carrier has not paid for the services in dispute. The respondent presented documentation to support that the insurance carrier issued payment of $279.03 to Memorial on March 27, 2019.

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 $711.16 for the disputed services. The respondent submitted documentation to support payment of $279.03 to Memorial.

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. The requestor has the burden at MFDR to support its position that additional reimbursement is due.

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

Conclusion

The findings in this decision are based on the information available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division concludes the requestor has been paid for the services in dispute. Additional reimbursement is not supported. As a result, the amount ordered is $0.00.

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	May 7, 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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). The division must receive the request within twenty days of your receipt of this decision.

The request may be faxed, mailed or personally delivered either to the field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** together with any other information required by 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.