



**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**

American Zurich Insurance Company

**MFDR Tracking Number**

M4-19-3607-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

March 27, 2019

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "A payment and or explanation of denial should have been processed according to Texas Department of Insurance."

**Amount in Dispute:** \$380.54

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The Carrier's records show this bill was paid per the attached EOB."

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

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 20, 2018	Tramadol HCl 50 mg Tablets and Meloxicam 7.5 mg Tablets	\$380.54	\$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.

**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 pharmaceutical services.

**Issues**

Is Memorial Compounding Pharmacy (Memorial) entitled to additional reimbursement?

**Findings**

Based on a review of the submitted documentation, the greater weight of evidence supports that the insurance carrier issued a payment of \$339.93 to Memorial on November 16, 2018, via check number 0002193146. The division concludes that Memorial has received payment for the drug in dispute.

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 Division’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 \$380.54 for the disputed drugs. 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 division’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 division 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 Division 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 division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

	Laurie Garnes	May 2, 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.**