



# 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**

Texas Mutual Insurance Co

**MFDR Tracking Number**

M4-19-3688-01

**Carrier's Austin Representative**

Box 54

**MFDR Date Received**

April 3, 2019

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "This claim has been denied incorrectly."

**Amount in Dispute:** \$202.85

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The provider has not shown that the amount requested for the meloxicam is consistent with Rule 134.503. No additional payment is due."

**Response Submitted by:** Texas Mutual Insurance

#### SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
September 11, 2018	Prescribed Medication	\$202.85	\$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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes
- 28 Texas Administrative Code §134.503 sets out the reimbursement for compound medications
- Explanation of Benefits:  
Issued October 11, 2018
  - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement

#### **Findings**

The Division makes the following conclusions based upon the information and documentation presented to the Division to date. Even though all the evidence was not discussed, it was considered.

- Did the carrier reimburse Memorial for the disputed services?

Memorial Compounding Rx (Memorial) asserts that the carrier has not paid for the service in dispute. Review of the explanations of benefits provided finds that the carrier issued a payment in the amount of \$1.75 on October 11, 2018.

The Division concludes that Memorial has received payment for the service in dispute.

*2. Is additional reimbursement due?*

The carrier reduced the billed amount to a total payment of \$1.75. Memorial is requesting reimbursement in the amount of \$202.85 for the disputed service. 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**

The Division concludes that Memorial has already been paid for the service in dispute. As a result, the amount ordered is \$0.00.

**ORDER**

Based on the submitted information, and pursuant to Texas Labor Code Section 413.031, the division has determined that the requestor is not entitled to additional reimbursement for the services in dispute.

**Authorized Signature**

_____	_____	_____
Signature	Medical Fee Dispute Resolution Officer	Date

**RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 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 with the Division. **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.**