



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 Co

MFDR Tracking Number

M4-19-3921-01

Carrier's Austin Representative

Box 19

MFDR Date Received

April 25, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The reconsideration was submitted and received by the carrier on 03/16/2019 via certified mail and then denied by the carrier."

Amount in Dispute: \$112.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...the amount Memorial is to be paid under its contract is confidential and proprietary, the Carrier does not know the amount Memorial would be entitled to..."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Table with 4 columns: Date of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: January 17, 2019, Diclofenac Sodium 1% Gel, \$112.32, \$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 reimbursement for compound medications

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.

- 1. 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 submitted documentation found payment was issued on March 28, 2019 to Memorial in the amount of \$72.53.

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 \$72.53. Rule at 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 \$112.32 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

May 21, 2019
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.