



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

Trumbull Insurance Company

MFDR Tracking Number

M4-19-4174-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

May 20, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We received the explanation of benefits but there was no reason for reduction or denial."

Amount in Dispute: \$132.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As reflected in the attached EOB, Trumbull properly reimbursed Memorial Compounding in accordance with the Division Fee Guideline and Texas Workers' Compensation Act."

Response Submitted by: Burns Anderson Jury & Brenner, L.L.P.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: July 11, 2018, Tramadol HCl 50 mg Tablets, \$132.92, \$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

Memorial is seeking additional reimbursement for Tramadol HCl 50 mg tablets dispensed on July 11, 2018. The carrier reduced the billed amount to a total payment of \$98.28 citing the workers’ compensation fee schedule as its reason for the reduction.

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 \$132.92 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 DWC’s medical fee dispute resolution program of the insurance carrier’s response and payment, Memorial did not take the opportunity to refute the insurance carrier’s payment calculation.

For that reason, the DWC 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 DWC 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 DWC hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

<p>Signature</p>	<p>Laurie Garnes Medical Fee Dispute Resolution Officer</p>	<p>August 13, 2019 Date</p>
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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.