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 RX

Respondent Name
XL Insurance America, Inc.

MFDR Tracking Number
M4-20-0598-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 4, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027."

Amount in Dispute: $198.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "See attached proof of payment."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 24, 2019	Acetaminophen/Codeine #3 Tablets	$66.03	$0.00
July 24, 2019	Ibuprofen 800 mg Tablets	$132.55	$0.00
		$198.58	$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 (DWC).

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 Rx (Memorial) entitled to additional reimbursement for the drugs in question?

Findings

Memorial is seeking additional reimbursement for drugs dispensed on July 24, 2019. The insurance carrier issued a payment in the amount of $112.47 to Memorial on September 30, 2019 with payment identification number 14TMB268121800. The DWC concludes that Memorial has received payment for the service in dispute.

The carrier reduced the billed amount citing the workers' compensation fee schedule as its reason for the reduction. Rule at 28 TAC §134.503(c) applies and states, in pertinent part, that the insurance carrier shall reimburse the lesser of:

(1) the fee established by the DWC'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 $198.58 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 used the methodology under 28 TAC §134.503(c).

After Memorial was notified by the DWC's medical fee dispute resolution program of the insurance carrier's response and payment, Memorial did not refute the carrier's payment calculation. For that reason, the DWC finds that Memorial is not entitled to additional reimbursement.

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

	Laurie Garnes	December 3, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.