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 RX

Respondent Name
Indemnity Insurance Company of North America

MFDR Tracking Number
M4-20-0893-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
December 10, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "A call was placed to carrier to confirm patient demographics as well as compensability. We were not notified of any disputes or PLN11 filed."

Amount in Dispute: $143.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… payment was issued to Memorial Compounding Pharmacy on 12/6/2019 for dates of service 8-16-19/8-16-19 in the amount of $43.81."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 16, 2019	Prescription Medications	$143.66	$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). 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

Issues

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

Findings

Memorial is requesting reimbursement in the amount of $143.66 for the disputed drugs. Based on the explanations of benefits dated August 21, 2019, Indemnity Insurance Company of North America denied payment based on entitlement to benefits. On reconsideration, the insurance carrier did not maintain its original

denial and decided to issue a payment in the amount of $43.81 to Memorial on December 6, 2019 via electronic funds transfer No. FE64854125. The DWC concludes that Memorial has received payment for the drugs in question.

The insurance carrier reduced the billed amount citing the workers' compensation fee schedule as its reason for the reduction. The insurance carrier shall reimburse the lesser of:

- the DWC's formula based on the average wholesale price (AWP) as reported by a nationally recognized publication of pharmaceutical pricing in effect on the day the prescription drug is dispensed; or
- the amount billed to the insurance carrier.[1]

Memorial has the burden to support its request for the disputed amount. In its position statement, Memorial did not explain how it arrived at the requested amount or whether that amount is based the method found in 28 TAC §134.503 (c).

After the DWC notified Memorial of the insurance carrier's response and payment, Memorial did not dispute the insurance carrier's claim of payment or its calculation. The DWC finds 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

	Laurie Garnes	December 20, 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.

[1] 28 TAC §134.503 (c)