



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

EMPLOYERS INSURANCE CO OF WAUSAU

MFDR Tracking Number

M4-20-2923-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

August 14, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The above claimant received medication and the carrier still has not acknowledged receipt of service. Reimbursement should be made to the provider of the claim has been submitted within the 95th day after the date on which the health care service was rendered."

Amount in Dispute: \$93.91

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We base our payments on the Texas Fee Guidelines and the Texas Department of Insurance Division of Workers' Compensation Acts and Rules. This is not a network claim. We have reviewed your dispute and found that the payment was issued on 5/22/20 in the amount of \$49.51. I have attached copy of EOB and cashed check status for your review."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: April 29, 2020, Naproxen Tablet, \$93.91, \$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.

3. Explanation of Benefits:

- 3 – Charge for pharmaceuticals exceed the fees established by the fee schedule

Findings

1. Memorial is seeking additional reimbursement for Naproxen tablet dispensed April 29, 2020. Per explanation of benefits dated May 22, 2020, the insurance carrier reduced the billed amount to a total payment of \$49.51 citing the workers’ compensation fee schedule as its reason for the reduction.

The insurance carrier is required to pay the lesser of the DWC’s pharmacy formulary 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 the billed amount.

Memorial is requesting an additional reimbursement of \$93.91 for the disputed drug. Memorial has the burden to support its request for this amount. 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) in its position statement.

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 carrier’s payment calculation. The DWC finds that no additional reimbursement can be recommended.


Conclusion

For the reasons stated above, the Division 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 division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature



Signature



Medical Fee Dispute Resolution Officer

January 28, 2021

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 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.