



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

Accident Fund Insurance Co of America

MFDR Tracking Number

M4-18-3546-01

Carrier's Austin Representative

Box 6

MFDR Date Received

May 24, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After reviewing the explanation of benefits, it indicates that the carrier paid \$0.00 and not the full amount of \$1086.61. This claim should be processed with the full amount billed as per Administrative Labor Code 134.503."

Amount in Dispute: \$1,086.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The EOB shows that the correct payment under the Division's fee guideline is \$963.96."

Response Submitted by: Stone, Loughlin Swanson

SUMMARY OF FINDINGS

Table with 4 columns: Date of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: October 10, 2017, Compound Medication, \$1,086.61, \$15.00

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:
Issued January 15, 2018
• 309 - The charge for this procedure exceeds the fee schedule allowance
Issued July 10, 2018
• W3 - Additional payment made on appeal/reconsideration

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

### **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 explanations of benefits provided finds that the carrier initially denied payment due to fee schedule exceeded. Upon reconsideration, the carrier did not maintain its original denial and decided to issue a payment in the amount of \$963.96 to Memorial on July 10, 2018.

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 \$963.96. 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 \$1,086.61 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 for the compounded medication.

#### *3. Is the compounding fee paid separately?*

The carrier denied the compounding fee of \$15.00 as 97 – "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." 28 Texas Administrative Code §134.503 (c) (1) (C) states, When compounding, a single compounding fee of \$15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; The carrier's denial is not supported.

### **Conclusion**

The Division concludes that the carrier paid for the services in dispute with the exception of the compounding fee. As a result, the amount ordered is \$15.00.

**ORDER**

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$15.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
August 10, 2018  
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.**