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
American Zurich Insurance Co

MFDR Tracking Number
M4-18-0503-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 25, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Texas Labor Code Section 408.027(b) requires that the carrier must pay, reduce, or deny or determine to audit the health care provider's claim no later than the 45th day after the date of receipt by the carrier. Memorial did not receive any correspondence as per rule…"

Amount in Dispute: $489.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was paid before the Requestor filed for dispute resolution…The Requestor should file a request to withdraw the dispute, unless it disagrees with the amount paid."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 25, 2017	Compound Cream	$489.96	$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 dated October 16, 2017:
   - P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment

- 4282 – Drugs identified with a status of "Y" in the current edition of the Official Disability Guidelines Treatment in Workers' Comp (ODG) / Appendix A, "ODG workers' compensation drug formulary" identify a drug that can be dispensed without preauthorization. The allowance has been determined in according to the pharmacy fee guidelines.
- 91 – Dispensing per adjustment.
- 1 – A dispensing fee is not applicable to the allowance of payment of the medication.

Findings

The service in dispute is a compound cream. 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.

Did the workers' compensation insurance carrier make a payment for the service in dispute?

Labor Code Sec. 408.027 (b), and corresponding 28 Texas Administrative Code §133.240 define the insurance carrier's responsibility when reviewing a medical bill for reimbursement. The carrier in this case was required to take final action by paying, reducing or denying the disputed services within 45 days after it received the complete medical bill in the manner prescribed by Rule §133.240.

Rule §133.240 (e) allows the carrier to provide either an electronic remit, or a paper explanation of benefits to the billing health care provider as a means of communicating payment of a medical bill. Documentation provided by the workers' compensation insurance carrier indicates that the carrier made a payment for the services in dispute.

Specifically, the carrier provided an explanation of benefits dated October 16, 2017 in which it paid $489.96 under check numbered 1737288.

Because the carrier paid the full disputed amount before this medical fee dispute was filed, the Division finds that no additional reimbursement is due to Memorial Compounding Pharmacy.

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, and pursuant to Texas Labor Code Section 413.031, the division has determined that the requestor is not entitled to additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	January 22, 2018
Signature	Medical Fee Dispute Resolution Officer	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.