



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

Zurich American Insurance Company

MFDR Tracking Number

M4-18-0649-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

November 10, 2017

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: \$196.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier's payment records reflect that Cypress Care (on behalf of the Carrier) issued a batch check to the Requestor on June 3, 2017, which included \$75.54 for the prescription the basis for this Request."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 5, 2017	Zolpidem Tartrate 5 mg Tablets	\$196.26	\$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 Pharmacy (Memorial) entitled to additional reimbursement?

Findings

Memorial is seeking reimbursement of \$196.26 for Zolpidem Tartrate dispensed on May 5, 2017. Documentation submitted by the insurance carrier supports that the it paid \$75.54 for the drug in question.

Memorial has the burden to support its request for the amount it seeks. In its original position statement, Memorial did not demonstrate how it arrived at the disputed amount.

After Memorial was notified by the DWC’s medical fee dispute resolution program of the insurance carrier’s response, it did not take the opportunity to refute the insurance carrier’s payment calculation.

For those reasons, the DWC moves to resolve this dispute with the information available and concludes 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	September 27, 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.