TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Memorial Compounding Pharmacy

**Respondent Name**
Texas Mutual Insurance

**MFDR Tracking Number**
M4-18-2093-01

**Carrier's Austin Representative**
Box 54

**MFDR Date Received**
February 16, 2018

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The carrier denied the original bill as well, and the reconsideration based on Invalid NDC #."

**Amount in Dispute:** $702.68

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "In order to resolve this fee reimbursement dispute Texas Mutual Insurance Company has elected to pay the disputed services."

**Response Submitted by:** Texas Mutual Insurance

## *SUMMARY OF FINDINGS*

| Date of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| July 27, 2017 | Compound Medication | $702.68 | $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:
   Issued August 17, 2017
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication

Issued December 14, 2017

- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

Issued March 8, 2018

- P12 – Workers' compensation jurisdictional fee schedule adjustment

**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 lack of information. Upon reconsideration, the carrier did not maintain its original denial and decided to issue a payment in the amount of $717.69 to Memorial on March 8, 2018.

The Division concludes that the carrier changed its original final action and decided to reimburse Memorial for the disputed amount.

Memorial was notified by the Carrier and by the Division's medical fee dispute resolution program that the full amount in dispute was paid, however Memorial has not taken the opportunity to refute the carrier's evidence or respond to the Division with additional information.

For that reason, the Division moves to resolve this dispute with the information available and concludes that no additional reimbursement can be recommended.

**Conclusion**

The Division concludes that Memorial has already been paid for the service in dispute. 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**

| | | March 29, 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**.