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
Service Lloyds Insurance Co

MFDR Tracking Number
M4-18-2168-01

Carrier's Austin Representative
Box 1

MFDR Date Received
February 21, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…Memorial Compounding Pharmacy has met the requirements to receive reimbursement."

Amount in Dispute: $726.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based upon clarifying documentation an allowance has been recommended for date of service 7/13/2017 in the amount of $744.35. An interest payment of $18.75 is included in the reimbursement."

Response Submitted by: Mitchell International Inc, 1350 Lakeshore Drive, Suite 100, Coppell, Texas 76019

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
July 13, 2017	Compound Medication	$726.62	$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 medications.
3. The carrier did not reduce the billed amount and/or paid at least the disputed amount in this case.

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 make a payment for the disputed services?

The carrier made a payment to Memorial in the amount of $744.35 on March 13, 2018.

The Division notified Memorial of the carrier's response. To date, Memorial has not taken the opportunity to refute the carrier's evidence of payment in this specific case. For that reason, the Division moves to resolve this dispute with the information available. The Division concludes that no reimbursement can be recommended.

Conclusion

The Division concludes that the carrier has issued payment. 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 23, 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.