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
American Zurich Insurance Company

MFDR Tracking Number
M4-18-3900-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 12, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After reviewing the explanation of benefits it indicates that carrier paid ($**263.47**) and not the full amount of **($630.04**). This claim should be processed with the full amount billed as per **Administrative Labor Code 134.503 C.**"

Amount in Dispute: $555.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This bill has been paid under terms of Memorial's contract with its PBM."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 14, 2017	Compound Medication	$555.68	$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

28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

Issues

Is the requestor entitled to additional reimbursement?

Findings

Memorial Compounding Pharmacy (Memorial) is seeking reimbursement for a compound dispensed on June 14, 2017, consisting of the following ingredients:

Ingredient	Disputed Amount
Baclofen	$190.78
Amantadine HCl	$72.69
Gabapentin USP	$204.66
Bupivacaine HCl	$54.72
Amitriptyline HCl	$32.83
Total	$555.68

Submitted documentation supports that Memorial was reimbursed in full for Baclofen and Amantadine HCl on October 16, 2017, via check #1737286. No evidence was submitted to support that the other ingredients in this dispute were submitted to the insurance carrier in accordance with 28 Texas Administrative Code §133.20. No further reimbursement is recommended.

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, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	May 23, 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 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. **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.