



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 RX

Respondent Name

TWIN CITY FIRE INSURANCE CO

MFDR Tracking Number

M4-19-0822-01

Carrier's Austin Representative

Box 47

MFDR Date Received

OCTOBER 15, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The above claimant received medication and the carrier still has not acknowledged receipt of service."

Amount in Dispute: \$35.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As reflected in the attached EOBs, Twin City approved reimbursement for the services provided by Memorial Compounding in accordance with the Division Fee Guideline."

Response Submitted by: Burns Anderson Jury & Brenner, LLP

SUMMARY OF FINDINGS

Table with 4 columns: Date of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: February 16, 2018, Compound Medication, \$35.04, \$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:
- P13-Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
- P12 - The charge for the procedure exceeds the amount indicated in the fee schedule.

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 fee guideline policies. Upon reconsideration, the carrier did not maintain its original denial and decided to issue a payment in the amount of \$35.04 to Memorial on November 6, 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

		12/07/2018
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.