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**
Zurich American Insurance Company

**MFDR Tracking Number**
M4-19-1348-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
November 8, 2018

## *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:** $123.09

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "This bill has been paid …"

**Response Submitted by:** Flahive, Ogden & Latson

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| June 15, 2018 | Hydrocodone/APAP 10/325 Tablets | $123.09 | $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). 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

**Issues**

Is Memorial Compounding Pharmacy (Memorial) entitled to additional reimbursement for the drug in question?

**Findings**

Memorial is seeking reimbursement for Hydrocodone/APAP 10/325 tablets dispensed on June 15, 2018. Memorial was notified by the insurance carrier and by the DWC's medical fee dispute resolution program that the drug was paid, however Memorial has not taken the opportunity to refute the insurance carrier's evidence

or responded to the DWC with additional information. For that reason, the DWC reviewed this dispute with the information available and concluded 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 | October 25, 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**.