



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 Pharmacy

Respondent Name

Truck Insurance Exchange

MFDR Tracking Number

M4-19-2210-01

Carrier's Austin Representative

Box Number 14

MFDR Date Received

December 17, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It looks like the carrier processed and paid only PARTIAL of the total bill."

Amount in Dispute: \$263.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include Baclofen and Amantadine HCl, with a Total row.

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

The insurance carrier's Austin representative acknowledged receipt of the copy of this medical fee dispute on December 31, 2018. The insurance carrier's response is considered timely if it is submitted within 14 calendar days after the date the insurance carrier's representative received the copy of the dispute. If a response is not received within 14 calendar days of the dispute notification, then the decision may be based on the available information.¹

No response has been received on behalf of Truck Insurance Exchange to date. For that reason, the decision will be based on the information available. 28 Texas Administrative Code §133.307 sets out the procedures for

¹ 28 Texas Administrative Code §133.307(d)(1)

resolving medical fee disputes.

Issues

Is Memorial Compounding Pharmacy (Memorial) entitled reimbursement for the ingredients in question?

Findings

Memorial is seeking reimbursement for ingredients Baclofen and Amantadine HCl. The division found no evidence to support that a bill for the ingredients in question was submitted to the insurance carrier as required by 28 Texas Administrative Code §133.20. Therefore, no 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 _____	_____ July 17, 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.