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
Markel Insurance Company

MFDR Tracking Number
M4-19-2280-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
December 20, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim should be processed with the full amount billed as per **Administrative Labor Code 134.503(c)**."

Amount in Dispute: $333.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The EOB clearly shows the compound drug as a whole was paid at the amount of $741.76."

Response Submitted by: Downs-Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 26, 2018	Compound Medication	$333.04	$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

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 drugs in question?

Findings

Memorial has requested reimbursement in the amount of $333.04. Memorial has the burden to support its request for this amount. In its original position statement, Memorial did not demonstrate how it arrived at the disputed amount. After Memorial was notified by the division's medical fee dispute resolution program of the insurance carrier's response, it did not take the opportunity to refute the insurance carrier's payment calculation or the insurance carrier's explanation of payment. For those reasons, the division moves to resolve this dispute with the information available and concludes that no additional reimbursement can be 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	January 18, 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.