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
Continental Casualty Co

MFDR Tracking Number
M4-19-4065-01

Carrier's Austin Representative
Box 57

MFDR Date Received
May 7, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The request for reconsideration in accordance with Rule 133.250 was submitted to the carrier but claim was processed and denied again."

Amount in Dispute: $160.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier respectfully submits its DWC-60 response with supporting documentation along with the parties' MDR Agreement."

Response Submitted by: Brian J Judis

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
January 10, 2019	Cyclobenzaprine 5 mg	$160.86	$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 medications

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 carriers' response indicates both parties agreed to a settlement for the disputed services

in the amount of $133.20 within 15 business days of both parties signature on this agreement. The Division concludes that Memorial has settled the service in dispute.

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

		June 6, 2019
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.