TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
Merged Connecticut Indemnity Company Into Arrowood Indemnity

MFDR Tracking Number
M4-19-4090-01

Carrier's Austin Representative
Box Number 11

MFDR Date Received
May 9, 2019

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: $245.60

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

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 4, 2019	Acetaminophen/Codeine #4 Tablets and Nabumetone 750 mg Tablets	$245.60	$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 fee guidelines for pharmaceutical services.
3. The submitted documentation did not include explanations of benefits for the drugs in question.

Issues

1. Did the insurance carrier respond to the medical fee dispute?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to additional reimbursement for the drugs in question?

Findings

1. The Austin carrier representative for Merged Connecticut Indemnity Company Into Arrowood Indemnity is Cunningham Lindsey Group, Ltd. Cunningham Lindsey Group, Ltd. acknowledged receipt of the copy of this medical fee dispute on May 17, 2019. Rule §133.307(d)(1) states that if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

   As of today, no response has been received from the insurance carrier or its representative. We therefore base this decision on the information available as authorized under 28 TAC §133.307(d)(1).

2. Memorial argued that it dispensed Acetaminophen/Codeine #4 Tablets and Nabumetone 750 mg Tablets on January 4, 2019. These are the drugs considered in this dispute. Memorial stated that it received partial payment for the drugs in question. However, no evidence was presented regarding the amount paid by the insurance carrier.

   Memorial is asking for $245.60 for the drugs in this dispute. Memorial has the burden to support its request for this amount. In its original position statement, Memorial did not demonstrate how it calculated the requested amount or how that amount is based on the calculation method in 28 TAC §134.503(c).

   Because Memorial did not include evidence of the prior payment for the drugs in question or support the amount requested, the DWC moves to resolve this dispute with the information available and finds that no additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the DWC finds that no reimbursement is due for the drugs in question. 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 3, 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.