



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

Service Lloyds Insurance Company

MFDR Tracking Number

M4-19-5357-01

Carrier's Austin Representative

Box Number 1

MFDR Date Received

August 30, 2019

Response submitted by:

AViDEL

REQUESTOR'S POSITION SUMMARY

"The charges were miscoded. Service item **00071-1015-68 LYRICA 100 MG CAPSULE P-D** was billed at **\$844.06**, but the Explanation of Benefits states that the charge was **\$44.06**, and it was paid for the miscoded amount of **\$44.06**."

RESPONDENT'S POSITION SUMMARY

"We are upholding the prior review. The first line was allowed in full per fee schedule..."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 24, 2019	Lyrica 100 mg P-D Capsules	\$800.00	\$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, effective May 31, 2012 sets out the procedures for resolving a medical fee dispute.

Issues

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

Findings

Memorial is seeking an additional reimbursement for Lyrica 100 mg capsules dispensed on May 24, 2019. Memorial submitted an explanation of benefits (EOB) dated June 19, 2019, with a reimbursement of \$44.06 for the drug in question.

In its response, AViDEL submitted an EOB on behalf of the insurance carrier. This EOB was dated July 12, 2019 and included a reimbursement of \$800.00 for the drug in question.

The DWC concludes that Memorial has been reimbursed the full amount billed to the insurance carrier. No further reimbursement is 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 upon the documentation submitted by the parties, the DWC has determined that the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

_____	Laurie Garnes	September 19, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

RIGHT TO APPEAL

Either party to this medical fee dispute may seek review of this division decision. To appeal, submit DWC Form-045M titled ***Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)*** found at <https://www.tdi.texas.gov/forms/form20numeric.html>.

Follow the instructions on pages 3 and 4. The request must be received by the DWC within twenty days of your receipt of this decision. This decision becomes final if the request for review of this decision is not timely made.

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.

If you have questions about the division Form-045M, please call CompConnection at 1-800-252-7031, Option 3 or you may email your question to CompConnection@tdi.texas.gov