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
North River Insurance Co

MFDR Tracking Number
M4-20-0140-01

Carrier's Austin Representative
Box 53

MFDR Date Received
September 16, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Texas Labor Code Section 408.027 (b) requires that the carrier must pay, reduce, deny or determine to audit the health provider's claim no later than the 45th day after the date of receipt by the carrier. Memorial did not receive any correspondence as per rule..."

Amount in Dispute: $334.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Enclosed herein is the EOB dated 09-23-19 which recommend reimbursement in the amount of $286.50 in accordance with the fee schedule."

Response Submitted by: Hoffman Kelley Lopez LLP

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
June 19, 2019	Prescribed medication	$334.84	$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 compound medications
3. Explanation of Benefits:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

Findings

DWC makes the following conclusions based upon the information and documentation presented to the DWC 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 insurance carrier has not paid for the service in dispute. The insurance carrier decided to issue a payment in the amount of $286.50 to Memorial on September 23, 2019.

DWC concludes that Memorial has received payment for the service in dispute.

2. Is additional reimbursement due?

The insurance carrier reduced the billed amount to a total payment of $286.50. Memorial is requesting reimbursement in the amount of $334.84 for the disputed service.

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 requested amount or whether that amount is consistent with the methodology under 28 TAC §134.503(c).

After notification by the DWC's medical fee dispute resolution program of the insurance carrier's response and payment, Memorial did not take the opportunity to refute the insurance carrier's payment calculation.

For that reason, DWC moves to resolve this dispute with the information available and concludes that no additional reimbursement can be recommended.

Conclusion

DWC 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

		October 24, 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 TAC §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to 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 with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.