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 RX

Respondent Name
STARR INDEMNITY & LIABILITY CO

MFDR Tracking Number
M4-20-0882-01

Carrier's Austin Representative
Box 19

MFDR Date Received
DECEMBER 10, 2019

REQUESTOR'S POSITION SUMMARY

"The above claimant received medication and the carrier still has not acknowledged receipt of service."

Amount in Dispute: $274.67

RESPONDENT'S POSITION SUMMARY

"Carrier will pay the monies are owed in the amount of $274.67. Interest in the amount of $2.26 will be issued on January 1, 2020."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
August 29, 2019	Compound Medication	$274.67	$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).

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:
    - 00663-Reimbursement has been calculated according to state fee schedule guidelines.
    - 00438-(197)-Precertification/authorization/notification/pre-treatment absent.
    - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
    - W3-Request for reconsideration.

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.

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 explanations of benefits provided finds that the carrier initially denied payment due to lack of preauthorization. Upon reconsideration, the carrier did not maintain its original denial and decided to issue a payment in the amount of $274.67 to Memorial on January 1, 2020.

The Division concludes that the carrier changed its original final action and decided to reimburse Memorial for the disputed amount.

Memorial was notified by the Carrier and by the Division's medical fee dispute resolution program that the full amount in dispute was paid, however Memorial has not taken the opportunity to refute the carrier's evidence or respond to the Division with additional information.

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

Conclusion

The 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 DWC has determined that the requestor is not entitled to additional reimbursement for the services in dispute.

Authorized Signature

		01/16/2020
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 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 with the DWC. **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.