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
American Casualty Co Of Reading Pa

MFDR Tracking Number
M4-20-1044-01

Carrier's Austin Representative
Box 57

MFDR Date Received
December 23, 2019

REQUESTOR'S POSITION SUMMARY

"I have attached the EOB's as well as the documentation to prove that Memorial Compounding Pharmacy has met the requirements to receive reimbursement."

Amount in Dispute: $202.85

RESPONDENT'S POSITION SUMMARY

"Carrier respectfully submits its supplemental **DWC-60 response with supporting documentation along with the parties' MDR agreement**."

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
September 6, 2019	Pharmacy Services Prescription Drug 29300-0125-10	$202.85	$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 TAC §133.307 sets out the procedures for resolving medical fee disputes
2. 28 TAC §134.503 sets out the reimbursement for compound medications
3. Explanation of Benefits:
    - 197 – Precertification/authorization/notification/pre-treatment absent.
    - 4121-Preauthorization is required for drugs identified with a status of 'N' in the current edition of the 'Official Disability Guidelines treatment in workers' comp' (ODG) Appendix A, 'ODG workers' Compensation Drug Formulary' and any updates.
    - W3-Additional payment made on appeal/reconsideration.
    - 131-Claim specific negotiated discount.
    - 193-Original payment decision is being maintained. Upon review, it was determined that

this claim was processed properly.

- 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Findings

The 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 carrier has not paid for the service in dispute. Review of the Medical Dispute Resolution Agreement dated January 14, 2020 indicates Memorial has agreed to payment in full of the dispute services in the amount of $185.69.

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

Conclusion

The DWC concludes that Memorial has agreed to an amount of $185.69 as payment in full 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

		January 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.