



# 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**

TEXAS MUNICIPAL LEAGUE INTERGOVERNMENTAL RISK

**MFDR Tracking Number**

M4-18-4026

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

June 19, 2018

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "These medications do not require preauthorization therefore do not need a retrospective review."

**Amount in Dispute:** \$566.53

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "... the Self-Insured has now paid these bills ..."

**Response Submitted by:** Flahive, Ogden & Latson

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 31, 2017	Compound Medication	\$566.53	\$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. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

**Issues**

Is Memorial Compounding Rx entitled to additional reimbursement?

**Findings**

Memorial is seeking reimbursement for a compound medication dispensed on October 31, 2017. Per explanation of benefits dated July 5, 2018, the insurance carrier reimbursed the requested amount in full. No additional 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 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**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
August 17, 2021  
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.**