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
Hartford Fire Insurance Co

MFDR Tracking Number
M4-18-0737-01

Carrier's Austin Representative
Box 47

MFDR Date Received
November 17, 2017

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 care 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: $71.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the carrier has decided to resolve this dispute. Attached is documentation of issuance of a check on December 4, 2017 in the amount of $71.92."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
May 26, 2017	Prescription Medication	$71.92	$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 medications.
3. The carrier did not reduce the billed amount and/or paid at least the disputed amount in this case.

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.

1. Did the carrier make a payment for the disputed services?

Memorial Compounding Rx (Memorial) asserts that it did not receive a response from the carrier up to the date that it filed this medical fee dispute. In its position, Memorial references Texas Labor Code Sec. 408.027 (b). This provision obligates the carrier to take final action by paying, reducing or denying the disputed services and issuing an explanation of benefits within 45 days after it has received the complete medical bill. The carrier in this case did not refute Memorial's assertion; however the carrier did decide to issue a payment for the service in dispute shortly after they were notified of this matter.

The carrier made a payment to Memorial in the amount of $71.92 on December 4, 2017 via check number 23841.

The Division notified Memorial of the carrier's response. To date, Memorial has not taken the opportunity to refute the carrier's evidence of payment in this specific case. For that reason, the Division moves to resolve this dispute with the information available. The Division concludes that no reimbursement can be recommended.

Conclusion

The Division concludes that the carrier has issued payment. 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

		March 15, 2018
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 Division within **twenty** days of your receipt of this decision. 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.

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 Division. **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.