TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Memorial Compounding Pharmacy

**Respondent Name**
Travelers Indemnity Co

**MFDR Tracking Number**
M4-18-0995-01

**Carrier's Austin Representative**
Box 05

**MFDR Date Received**
December 8, 2017

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The carrier recommending a payment of $284.94 but payment was never issue or received by the provider."

**Amount in Dispute:** $284.94

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The Provider submitted their billing through the PBM to issue payment and the Carrier transferred funds to the PBM. The PBM then issued payment to the Provider, which has been deposited. Note the date of service, billing codes, and quantity on the Explanation of Reimbursement match the codes on the billing and Table of Dispute Service. The Provider has been reimbursed for the dispute services, and no additional reimbursement is due."

**Response Submitted by:** Travelers

## *SUMMARY OF FINDINGS*

| Date of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| April 21, 2017 | Prescription Medication | $284.94 | $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:
   Issued May 25, 2017
   - 97 – Paid – Provider Billed Amount

**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.

Documentation supports the carrier made a payment to Memorial in the amount of $284.94 on May 26, 2017 via check number 651043. Memorial's assertion that it did not receive a response from the carrier is therefore unsupported.

The Division concludes that the carrier issued payment for the disputed service before Memorial filed this medical fee dispute.

**Conclusion**

The Division 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**

| | Peggy Miller | April 27, 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**.