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
GREAT WEST CASUALTY COMPANY

MFDR Tracking Number
M4-19-0734-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
October 11, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027. Rule 133.250 allows provider to request for medical dispute in accordance with Rule 133.305 if dissatisfied with the carrier. Memorial Compounding has fulfilled the required rule to receive reimbursement."

Amount in Dispute: $555.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Department of Insurance, Division of Workers' Compensation does not have jurisdiction to adjudicate this medical fee dispute. See the enclosed PLN-1. Therefore, the medical fee dispute should be withdrawn from any Texas adjudication process. The Carrier agrees to pay for the bill in question bill per Kentucky fee schedule and guidelines. Once it is processed, payment will be issued directly to the provider in accordance with Kentucky law."

Response Submitted by: Great West Casualty Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
May 28, 2018	Prescribed Medications	$555.68	$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.

Findings

The requester seeks reimbursement for prescribed medications rendered on May 28, 2018. The Division's Medical Fee Dispute Resolution (MFDR) section is unable to resolve this dispute. Per 28 Texas Administrative Code §133.307(a)(3), "In resolving non-network disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the Division of Workers' Compensation (Division) is to adjudicate the payment, given the relevant statutory provisions and Division rules."

Upon review, the submitted documentation supports that the injured employee has received benefits under the worker's compensation laws of the state of Kentucky. Consequently, this fee dispute is not within the jurisdiction of the Division of Workers' Compensation, as it does not involve a Texas workers' compensation claim. The Division therefore finds that the requestor does not have the right to file for medical fee dispute resolution under 28 Texas Administrative Code §133.307.

Conclusion

The Division concludes that it does not have jurisdiction over the services in dispute. This request for medical fee dispute resolution is dismissed for good cause in accordance with 28 Texas Administrative Code §133.307(f)(3)(D).

DISMISSAL

The Division has determined that the requestor does not have the right to file for medical fee dispute resolution. The request for medical fee dispute resolution is hereby dismissed.

Authorized Signature

		January 24, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR 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.