TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Memorial Compounding Pharmacy

**Respondent Name**
United Airlines Inc

**MFDR Tracking Number**
M4-19-1985-01

**Carrier's Austin Representative**
Box 19

**MFDR Date Received**
December 6, 2018

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The carrier denied the reconsideration based on partial payment."

**Amount in Dispute:** $450.16

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The Carrier has learned that the PBM has paid this bill."

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

## *SUMMARY OF FINDINGS*

| Date of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| April 15, 2018 | Compound Pharmacy | $450.16 | $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:
   January 28, 2019
   - Payment indicated in the amount of $555.68

**Findings**

DWC 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 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 explanations of benefits provided finds that the carrier issued a payment in the amount of $555.68 to Memorial on January 28, 2019 via check number 31853.

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

**Conclusion**

DWC 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**

| | | |
|---|---|---|
| | | September 11, 2019 |
| 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 TAC §133.307, 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 DWC 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 TAC §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.