



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 RX

Respondent Name

United Airlines, Inc.

MFDR Tracking Number

M4-19-2873-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

January 24, 2019

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."

Amount in Dispute: \$333.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This bill was paid in accordance with Memorial's PBM contract. A copy of the check and remittance advice is attached."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 29, 2018	Prescription Drugs	\$333.04	\$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 (DWC). 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

Issues

Is the requestor entitled to additional reimbursement?

Findings

Memorial is seeking reimbursement of \$333.04 for drugs dispensed on August 29, 2018. Memorial was notified by the insurance carrier and by DWC's medical fee dispute resolution program that it made a payment on the drugs in question.

Memorial has the burden to support its requested amount. In its original position statement, Memorial did not demonstrate how it arrived at the disputed amount. After Memorial was notified by DWC's medical fee dispute resolution program of the insurance carrier's response, it did not take the opportunity to refute the insurance carrier's payment. For those reasons, DWC moves to resolve this dispute with the information available and concludes that no additional reimbursement can be recommended.

Conclusion

For the reasons stated above, 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

_____	<u>Laurie Garnes</u>	<u>December 13, 2019</u>
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 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.