



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

Sentry Insurance A Mutual Co

MFDR Tracking Number

M4-20-2009-01

Carrier's Austin Representative

Box 19

MFDR Date Received

April 17, 2020

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 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: \$267.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We verified that the 2 pharmacy bills for DOS 1/29/20 with the total billed amount of \$616.01 paid a total of \$498.51. A bulk check in the amount of \$5919.21 was issued to the provider on check #0002348106 with check date 4/17/20."

Response Submitted by: Sentry Insurance

SUMMARY OF FINDINGS

Table with 4 columns: Date of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: January 29, 2020, Oral medication, \$616.01, \$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

28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes

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.

Memorial Compounding Rx (Memorial) asserts that the carrier has not paid for the service in dispute. Review of the carriers' response indicates payment was made on all four oral medications in dispute.

The requestor's position is not supported.

**Conclusion**

The Division concludes that Memorial has already been paid for the service in dispute. As no supplemental position was submitted that disputed the adjudicated fee, no additional payment is ordered.

***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**

Signature	Medical Fee Dispute Resolution Officer	Date
		May 8, 2020

***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.**