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
GREAT WEST CASUALTY COMPANY

MFDR Tracking Number
M4-18-4670-01

Carrier's Austin Representative
Box 01

MFDR Date Received
August 2, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please reconsider the bills for payment..."

Amount in Dispute: $566.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...we aren't disputing this one. I've approved proof of payment for 12-11-17 bill."

Response Submitted by: Great West Casualty Company

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount in Dispute	Amount Due
December 11, 2017	Prescribed Medication	$566.53	$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: March 9, 2018 and May 18, 2018
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - 197 – Precertification/authorization/notification absent

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 reimburse Memorial for the disputed services?

Memorial Compounding Rx (Memorial) asserts that the carrier has not paid for the service in dispute. The insurance carrier submitted a copy of the check issuing payment in the amount of $834.03 to Memorial on August 1, 2018 via check number 4920155.

The Division concludes that the carrier reimbursed Memorial for the full disputed amount. For that reason, the Division moves to resolve this dispute with the information available and concludes that no additional reimbursement can be recommended.

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

		October 17, 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.