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
ZURICH AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-18-3731-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 4, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the reconsideration based on unresolved issues of extent of injury. A call was placed to carrier to confirm patient demographics as well as compensability. We were not notified of any disputes or PLN11 filed... Any dispute filed should be processed prior to the date of service in question."

Amount in Dispute: $90.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has no liability for this fictitious injury. The claim was denied from the beginning. The ALJ's Decision and Order of September 14, 2017 found the claimant did not sustain an injury in the course and scope of her employment... The Requestor cannot show itself eligible for payment from the Carrier, and the Division has no jurisdiction to order payment on a non-compensable, fictitious injury."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
September 1, 2017	Prescribed Medication	$90.26	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305, sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P6 – Based on entitlement to benefits

Issues

1. Has the compensability issue been resolved?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury.

   28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021."

   The service in dispute as denied, due to a compensability issue. The issues raised and relevant to the services in this medical fee dispute, involved whether the injured employee sustained a compensable injury on [redacted]. A contested case hearing was held and a decision and order was issued on September 14, 2017. The division concluded that the claimant did not sustain a compensable injury on [redacted]. The Appeals Panel Decision dated October 20, 2017, affirmed that the claimant did not sustain a compensable injury on [redacted]. The division finds that the relevant compensability issue was resolved.

2. Review of the submitted documentation indicates that the provider's prescribed medications, were rendered for date of injury [redacted]. The division concludes that the services in dispute were rendered by the requestor to treat an injury found to be non-compensable according to the Contested Case Hearing and Appeals Panel decisions discussed above. For that reason, reimbursement cannot be recommended for the disputed service.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 19, 2018 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, 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 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 MDR decision shall deliver a copy of the request to all 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*** along 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.