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
BITCO NATIONAL INSURANCE COMPANY

MFDR Tracking Number
M4-18-4526-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 30, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial Compounding Pharmacy has received several denials for bill with date of service (11/14/2017). The carrier denied the original bill as well, and the reconsideration based on ENTITLEMENT TO BENEFITS. I have attached the EOB's as well as the documentation to prove that Memorial Compounding Pharmacy has met the requirements to receive reimbursement."

Amount in Dispute: $726.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has no liability for this claimed injury. The claim was denied from the beginning. The ALJ's Decision and Order of January 17, 2018 found the claimant did not sustain an injury in the course and scope of his employment... The Carrier's EOB denying entitlement is attached."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY

Dates of Service	Disputed Service	Amount in Dispute	Dismissal
November 14, 2017	Compound Cream	$726.62	Not eligible for review

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 (CCH) was held, and a decision and order was issued on January 17, 2018. The division concluded that the claimant did not sustain a compensable injury on [redacted]. The Appeals Panel Decision 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 supports that the provider's prescribed medications, were rendered to treat 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 CCH 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	August 24, 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.