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 PHARMACY

**Respondent Name**
TRAVELERS INDEMNITY COMPANY

**MFDR Tracking Number**
M4-19-1387-01

**Carrier's Austin Representative**
Box Number 05

**MFDR Date Received**
November 8, 2018

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Please review and pay in accordance with the fee schedule along with the appropriate interest."

**Amount in Dispute:** $90.26

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The Carrier investigated the claim and determined it was not compensable as the Claimant did not sustain damage or harm to the physical structure of the body in the course and scope of employment... The Carrier contends the Provider is not entitled to reimbursement. The Carrier, therefore, respectfully requests the Division determine no reimbursement is due for this service."

**Response Submitted by:** Travelers

## *SUMMARY OF FINDINGS*

| Date(s) of Service | Disputed Service(s) | Amount in Dispute | Amount Due |
|---|---|---|---|
| April 25, 2018 | 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:
   - 27 – Expenses incurred after coverage terminated

**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 services in dispute were denied, due to an unresolved compensability issue. The disputed issue involved whether the claimant sustained a compensable injury on [redacted]. A Contested Case Hearing (CCH) was held on June 7, 2018. The division concludes that the claimant did not sustain damage or harm to the physical structure of his body while in the course and scope of his employment on [redacted].

2. Review of the documentation submitted indicates that the provider billed for its services under date of injury, [redacted]. The services in dispute were rendered for an injury which was determined non-compensable according to the CCH outcome rendered on June 7, 2018. The requestor rendered health care to this injured employee for the non-compensable date of injury of [redacted]; therefore, no reimbursement can be recommended for the services in dispute.

**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 | December 13, 2018<br>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**.