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

MFDR Tracking Number
M4-19-1638-01

MFDR Date Received
November 20,2 018

Respondent Name
Brown Sims

Carrier's Austin Representative
Box Number 15

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: $702.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is Respondent's position that it appropriately denied payment of Requestor's invoice… Additionally, an extent of injury dispute existed amount the parties. …Per (physician) and the Contested Case Hearing decision, the treatment made subject to this medical fee dispute is not reasonable, necessary, or related to the May 4, 2017 work injury. Therefore, Respondent is not responsible for processing and payment of this claim."

Response Submitted by: Brown Sims

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
June 28, 2018	Baclofen, Amantadine, Gabapentin, Bupivacaine, Amitriptyline, Ethoxy Diglycol, Versapro Cream, Compounding fee	$702.68	$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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 sets out the procedure for dispute resolution.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 166 – These services were submitted after this payers responsibility for processing claims under this plan ended
   - 197 – Precertification/authorization absent
   - 18 – Exact duplicate claim/service

Issues

1. Have the relevant compensability issues 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, in part, due to unresolved extent of injury issues. The issues raised and relevant to the services in this medical fee dispute involved whether the compensable injury extended to and include disc protrusions at L4-L5 and L5-S1.

   A contested case hearing was held and a decision was issued on September 19, 2018. In its decision, the division concluded that compensable injury of May 4, 2017 **did not extend to or include** disc protrusions at L4-L5 and L5-S1 and claimant reached maximum medical improvement on February 21, 2018 prior to the disputed date of service. The respondent's position of "Respondent is not responsible for processing and payment of this claim'" is supported.

2. 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 decision discussed above. For that reason, no reimbursement can be recommended.

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 30, 2019 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 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.