



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

M4-19-1887-01

MFDR Date Received

November 30, 2018

Respondent Name

ACE AMERICAN INSURANCE COMPANY

Carrier's Austin Representative

Box Number 15

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: \$702.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill for date of service 5/28/18 was denied for charge unrelated to the compensable injury. Carrier maintains the position that the provider is not eligible for reimbursement as this is disputed claim. The case went to CCH. The Decision & Order was in Carrier's favor. Attached are copies of the PLN1 and Decision & Order."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
May 28, 2018	Compound Medication	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.305 sets out the procedure for dispute resolution.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 62 – No proof of pre-auth

Issues

- Have the relevant compensability issues been resolved?
- Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for compound prescription rendered on May 28, 2018. 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 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 was issued on September 7, 2018. In its decision, the division concluded that the claimant did not sustain a compensable injury on [REDACTED]. The division finds that the relevant issues were resolved.
2. Review of the submitted medical documentation supports that the requestor rendered services 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 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	January 4, 2019 Date
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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.