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
Texas Mutual Insurance Company

MFDR Tracking Number
M4-19-3602-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 27, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial Compounding Pharmacy has met the requirements to receive reimbursement."

Amount in Dispute: $247.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual maintains its denial position … as indicated on the EOB contained in the requester's DWC60 packet."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 12, 2018	Meloxicam 7.5 mg Tablets	$247.62	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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. Texas Labor Code §408.021 establishes entitlement to medical benefits.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - CAC-165 – Referral absent or exceeded.
   - 855 – Medications not prescribed by or at the direction of the treating doctor as required by DWC rule.
   - 859 – Documentation does not support the continued use of the medication for this patient

- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed
- 891 – No additional payment after reconsideration

Issues

Are Texas Mutual Insurance Company's reasons for denial of payment supported?

Findings

Memorial Compounding Pharmacy is seeking reimbursement for Meloxicam 7.5 mg tablets dispensed on November 12, 2018. Texas Mutual Insurance Company denied the disputed service with claim adjustment reason code 855 – "MEDICATIONS NOT PRESCRIBED BY OR AT THE DIRECTION OF THE TREATING DOCTOR AS REQUIRED BY DWC RULE." Texas Labor Code §408.021(c) requires that "Except in an emergency, all health care must be approved or recommended by the employee's treating doctor."

Review of the submitted information does not support that the disputed drug was provided by **or recommended by** the employee's treating doctor. The insurance carrier's denial reason is supported. Reimbursement of the disputed drug cannot be recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	Date
	Laurie Garnes	August 29, 2019

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **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.