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**
Service Lloyds Insurance Company

**MFDR Tracking Number**
M4-19-4613-01

**Carrier's Austin Representative**
Box Number 1

**MFDR Date Received**
June 24, 2019

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Memorial Compounding is an approved provider and should be reimbursed accordingly. The referral provider has been treating the patient for the injury sustained at work."

**Amount in Dispute:** $164.81

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "We are upholding the prior review. Prescribing Doctor, Anibal Rossel, was not the treating doctor when this prescription was filed thus was not an authorized treating doctor."

**Response Submitted by:** AViDEL

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| April 22, 2019 | Cyclobenzaprine 10 mg Tablets | $90.25 | $0.00 |
| April 22, 2019 | Acetaminophen/Codeine #3 Tablets | $74.56 | $0.00 |
| | Total | $164.81 | $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 defines entitlement to benefits.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 242 – Not treating doctor approved treatment
   - 375 – Please see special *NOTE* below.
   - B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 282 – The insurance company is reducing or denying payment after reconsidering a bill
- Note: "STANDING ON PRIOR DENIAL. PRESCRIBING PROVIDER IS NOT AN AUTHORIZED TREATING DOCTOR."

**Issues**

Are the insurance carrier's reasons for denial of payment supported?

**Findings**

Memorial is seeking reimbursement for drugs dispensed on April 22, 2019. The insurance carrier denied the disputed drugs stating that it was "NOT TREATING DOCTOR APPROVED TREATMENT." Except in an emergency, all health care must be approved or recommended by the employee's treating doctor.[1]

The DWC finds that Dr. Rossel, the prescribing doctor, was not the injured employee's treating doctor on the date of service in question. No evidence was presented to support that the treating doctor approved the treatment or referred the injured employee to Dr. Rossel.

No reimbursement can be recommended.

**Conclusion**

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**

| | Laurie Garnes | August 30, 2019 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

***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**.

[1] Texas Labor Code §408.021(c)