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 RX

Respondent Name
Travelers Casualty Insurance Company of America

MFDR Tracking Number
M4-20-0602-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
November 4, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027."

Amount in Dispute: $293.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Claimant filed a third-party claim against the party responsible for causing the motor vehicle accident which led to his workers compensation injuries. That claim settled at mediation in May 2019, prior to the date of service at issue in this Request for Medical Fee Dispute Resolution. As a result of the settlement to the Claimant, the Carrier has a statutory credit under Texas Labor Code Sect. 417.002(b) … which has not been exhausted. Under the requirements of Chapter 417 for the Texas Labor Code, the Claimant is responsible for payment of all benefits, including medical benefits, for his workers compensation claim until the credit is exhausted."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 26, 2019	Meloxicam 15 mg Tablets & Cyclobenzaprine 10 mg Tablets	$293.10	$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 (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §417.002 outlines the process for recovery in third-party settlements.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 96 – Non-Covered Charge Rx Number 6542888 reduced $90.25
   - 96 – Non-Covered Charge Rx Number 6542887 reduced $202.85

Issues

Is the insurance carrier's denial of payment for the drugs in question supported?

Findings

Memorial is seeking reimbursement from Travelers Casualty Insurance Company of America for drugs dispensed on July 26, 2019. The insurance carrier denied payment as non-covered charges.

In its position statement, the insurance carrier indicated that a third-party settlement had been reached under Texas Labor Code Sect. 417.002 for this injury and was not exhausted. After it was notified of the insurance carrier's position, Memorial did not take the opportunity to submit a rebuttal to the DWC.

If a claimant receives an advance from a third-party settlement for future medical benefits, the workers' compensation insurance carrier is not required to resume payment of benefits until the advance is exhausted.[1]

The DWC found no evidence to support that the advance was exhausted, and that Travelers Casualty Insurance Company of America was required to resume payment of medical benefits. The DWC concludes that the insurance carrier's denial of payment for the drugs in question is supported. No reimbursement is 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	January 8, 2020
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 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 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 Sect. 417.002 (a-c)