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 Co

MFDR Tracking Number
M4-20-2014-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
April 16, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: None submitted.

Amount in Dispute: $145.41

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual denied the bill due to early refill as the medication was previously billed and paid for a 60 days supply. Next refill would be on or around 2/1/2020. No payment is due."

Response submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 20, 2020	Oral medication	$145.41	$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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 154 – Payer deems the information submitted does not support this day's supply
   - 856 – Early refill: Documentation has not been submitted to substantiate dispensing this medication prior to previous RX being exhausted
   - 193 – Original payment decision is being maintained.

Issues

Does the request for MFDR comply with DWC rules?

Findings

The requestor is seeking reimbursement of $145.41 for an oral medication dispensed January 20, 2020. The insurance carrier denied the disputed service as an early fill. The requestor presented no position statement as to why the disputed services should be paid per applicable DWC fee guideline.

28 TAC 133.307 (2)(c)(N) states in pertinent part, the requestor shall provide records with the request for MFDR that include a position statement that shall include the requestor's reasoning for why the disputed fees should be paid, how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues, and how the submitted documentation supports the requestor's position for each disputed fee issue.

Review of the submitted documentation found insufficient evidence to support the requestor met this requirement of requesting MFDR.

No additional payment is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment 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 division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		May 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.