



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

MFDR Tracking Number

M4-18-4525-01

MFDR Date Received

July 30, 2018

Respondent Name

Hartford Underwriters Insurance

Carrier's Austin Representative

Box Number 47

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier is required to provide a response of the bill in order for the HealthCare Provider to rebuttal properly. As of today we still haven't received this check or a proper explanation of denial."

Amount in Dispute: \$555.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier denied reimbursement based on extent of the compensable injury, contending the medications in dispute were not provided to treat the compensable injury."

Response Submitted by: Burns Anderson Jury & Brenner, LLP

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
December 12, 2017	Compound pharmacy	\$555.68	\$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:
 - P2 – Not a work related injury/illness and thus not the liability of the workers' compensation carrier

Issues

- Have the relevant compensability issues been resolved?

Findings

- 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 services in dispute were denied due to unresolved extent of injury issues. 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

_____	_____	June , 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 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.