



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

EZ Scripts

**Respondent Name**

Union Insurance Co.

**MFDR Tracking Number**

M4-24-2987-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

August 28, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 15, 2024 – March 25, 2024	Pharmaceutical Services	\$595.28	\$0.00

### Requestor's Position

"Berkley Southwest issued payment for some of the medications prescribed by NC-P Arvin Garcia of Injury Center of Houston and Dr. Sara Goel's office ... Dr. Sara Goel and her nurse practitioner's treatment is authorized."

**Amount in Dispute:** \$595.28

### Respondent's Position

"... the treating provider on record, Derick Stanson, D.C., referred the injured employee to Sara Goel, D.O., for pain management. However, the prescriber on the denied bills was Arvi Garcia, NP, whose affiliation is unknown. As no additional information was provided, upon reconsideration, the bill was again denied ..."

**Response Submitted by:** Flahive, Ogden & Latson

## Findings and Decision

### Authority

This medical fee dispute is decided according to [Texas Labor Code \(TLC\) §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

### Statutes and Rules

1. [TLC §408.021](#) sets out entitlement to medical benefits.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.

### Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- ANSI185 – The rendering provider is not eligible to perform the service billed.
- B1025 – Provider not authorized
- 148 – This procedure on this date was previously reviewed
- ANSI18 – Exact duplicate claim/service

### Issues

1. Is the insurance carrier's denial of the drugs in question supported?

### Findings

1. EZ Scripts is seeking reimbursement for drugs dispensed from January 15, 2024, through March 25, 2024. The insurance carrier denied payment, in part, stating, "Provider not authorized."

TLC §408.021(c) states, "Except in an emergency, all health care must be approved or recommended by the employee's treating doctor." DWC found no documentation to support that the drugs in question were approved or recommended by the treating doctor. Therefore, DWC finds that the insurance carrier's denial of payment is supported. No reimbursement is recommended.

### Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requestor has not established that reimbursement is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 reimbursement for the disputed services.

### Authorized Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
January 8, 2025

\_\_\_\_\_  
Date

### Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at [www.tdi.texas.gov/forms/form20numeric.html](http://www.tdi.texas.gov/forms/form20numeric.html). DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option three or email [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in [28 TAC §141.1 \(d\)](#).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción tres o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).