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
American Specialty Pharmacy

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-15-3863-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 27, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This treatment is necessary to achieve a therapeutic outcome … This medication is medically necessary in order to decrease pain, reduce the need for narcotics and/or other prescription analgesics and to preserve function of the patient."

Amount in Dispute: $1344.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual has no record preauthorization was sought or obtained nor has the requestor provided any evidence of preauthorization approval in its DWC60 packet."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 27, 2015	Prescription Medication (Compound Cream)	$1344.32	$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. 28 Texas Administrative Code §133.250 sets out the procedures for requests for reconsideration of medical bills.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes: No explanations of benefits were found in the submitted documentation.

Issues

Does a dispute exist for the services in question?

Findings

The requestor is seeking reimbursement for prescription medication services for date of service February 27, 2015. The explanation of benefits in the submitted documentation is for date of service March 31, 2015. The submitted fax confirmation dated March 31, 2015 is for a bill submitted for date of service March 31, 2015. There is a fax confirmation dated May 19, 2015 that indicates a bill for date of service February 27, 2015 may have been submitted. However, submitted documentation does not include an explanation of benefits for this submission, nor was documentation found to support that a request for an explanation of benefits for date of service February 27, 2015 was made according to 28 Texas Administrative Code §133.250.

For the reasons stated above, no dispute of the date of service in question can be established.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional 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

	Laurie Garnes	September 24, 2015
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, 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 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.