TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
Trumbull Insurance Co

MFDR Tracking Number
M4-17-0738-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
November 16, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached bills have been denied by the carrier stating no preauthorization. Memorial Compounding Pharmacy has done reconsiderations on all bills. The reconsiderations were either denied after reconsideration or never responded to."

Amount in Dispute: $3,960.63

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…without sufficient information to support the requested service and an explanation for why the patient required compounded agents not supported for topical application, the requested service is non-certified."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 8, 2016 January 28, 2016 February 15, 2016 February 29, 2016 March 15, 2016 April 14, 2016	Pharmacy compounds	$3,960.63	$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 §134.530 sets out guidelines for pharmacy services.
3. The insurance carrier denied payment for the disputed services with the following claim adjustment codes:
   - 75 – No explanation
   - 21 – No explanation
   - 85 – No explanation

Issues

1. Is the respondents' position supported?

Findings

1. The respondent states, "without sufficient information to support the requested service and an explanation for why the patient required compounded agents not supported for topical application, the requested service is non-certified."

   Review of the submitted documentation found on November 6, 2015 the insurance carrier submitted a request to the prescribing physician for supporting medical information but, was unsuccessful in obtaining information why the patient had been prescribed the medication.

   28 TAC 134.530 (g) states in pertinent parts,

   > Except as provided in subsection (f)(1) of this section, drugs that do not require preauthorization are subject to retrospective review for medical necessity in accordance with §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) and §133.240 of this title (relating to Medical Payments and Denials), and applicable provisions of Chapter 19 of this title.
   >
   > > (3) A prescribing doctor who prescribes pharmaceutical services that exceed, are not recommended, or are not addressed by §137.100 of this title, is required to provide documentation upon request in accordance with §134.500(13) of this title (relating to Definitions) and §134.502(e) and (f) of this title.

   Based on the above the respondent's position is supported. No additional payment is recommended.

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 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

		June 27, 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 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.