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
Liberty Mutual Insurance Co

MFDR Tracking Number
M4-18-3862-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
June 8, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the original bill as well, and the reconsideration based on lack of preauthorization."

Amount in Dispute: $555.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill has been reviewed and denial stands for as per Peer Review."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 13, 2017	Compound Medications	$555.68	$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 Insurance Code §4201 sets out the requirements of utilization review.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - X435 – Based on peer review, further treatment is not recommended. For TX jurisdiction claims only, per TX Labor Code sec. 413.031 and 28 TAC Sections 133.308(H), (I), after reconsideration, you may seek review of a denial of medical necessity through a TDI-DWC-appointed independent review organization

Issues

1. Is the carrier's position statement supported?

Findings

1. The requestor is seeking reimbursement for compound medication dispensed on October 13, 2017. The insurance carrier states in their position, "…denial stands for as per Peer Review.

   Texas Insurance Code §4201.002(13) states in relevant part "Utilization review" includes a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services"

   The division found evidence that the carrier engaged in a retrospective utilization review (UR) as required by Texas Insurance Code §4201.002. Specifically notification of an unfavorable retrospective review performed for date of service October 13, 2017 by Liberty Mutual Manager Care LLC (LMMC), a certified utilization review agent, for Baclofen/Amantadine/Gabapentin/Bupivacaine/Amitriptyline, dispensed on November 2, 2017.

   Further review found the requestor was notified of this unfavorable retrospective review on November 2, 2017.

   The carrier'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

		July 10, 2018
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.