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

Respondent Name
Trumbull Insurance Co

MFDR Tracking Number
M4-18-4087-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 25, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The NDC number provided is a valid NDC number and claim should be processed accordingly."

Amount in Dispute: $566.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please accept this letter as response to the above dispute. Our investigation shows the following: Retro Revie performed on the disputed medication, Determination was non-certified, Correspondence was faxed to Dr. Nash & Memorial Compounding RX."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 12, 2017	Pharmacy Services - Compounds	$566.53	$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 §134.503 sets out the fee guidelines for pharmaceutical services.
3. 28 Texas Administrative Code §134.530 sets out prior authorization requirement for pharmacy services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization/notification absent

Issues

1. Is the respondent's position supported?
2. Is the requestor entitled to reimbursement for the compound in question?

Findings

1. The respondent states in their position, "…Retro Review performed on the disputed medication, Determination was non-certified."

   Review of the submitted documentation found Notice of Adverse Determination-WC Network dated April 10, 2018. The insurance carrier supported notification of the adverse determination to Memorial Compounding Pharmacy on April 10, 2018 at 4:14:16 pm. The insurance carrier's position is supported.

2. The requestor is seeking reimbursement of $566.53 for a compound dispensed October 12, 2017.

   28 TAC §134.530(g) states in pertinent parts,

   > Retrospective review. 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.
   >
   > (2) In order for an insurance carrier to deny payment subject to a retrospective review for pharmaceutical services that are recommended by the division's adopted treatment guidelines, §137.100 of this title, the denial must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established under Labor Code §413.017.

   The adverse determination submitted by the insurance carrier states, "The records submitted for review would not support the requested compounded medication as reasonable or necessary. The use of compounded medications is not supported by current evidence-based guidelines…"

   While precertification of the disputed services was not required, the retrospective review done by the insurance carrier denied authorization of the disputed services. Memorial Compound Pharmacy was notified of this adverse determination prior to the request for MFDR. No 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 21, 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.