TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Memorial Compounding Rx

Respondent Name
New Hampshire Insurance Co.

MFDR Tracking Number
M4-18-4270

Carrier's Austin Representative
Box Number 9

DWC Date Received
July 12, 2018

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 28, 2017	Pharmaceutical Compound	$555.68	$0.00

Requestor's Position

These medications do not require preauthorization therefore do not need a retrospective review.

Amount in Dispute: $555.68

Respondent's Position

The Carrier has denied reimbursement at the purported prescribing doctor is not the injured workers' treating doctor, and there is no documentation that Dr. Nash was authorized to prescribe any medication for this patient.

Response Submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules

of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §133.210 sets out the guidelines for medical documentation.

3. Texas Labor Code §408.021 sets out the requirements for entitlement to medical benefits.

Denial Reasons

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

- 26K10 – Resolution manager denial
- ADJ – The doctor is not authorized to prescribe medication
- 50 – These are non-covered services because this is not deemed a 'medical ecessity' by the payer.
- 197 – Precertification/authorization/notification absent

Issues

1. Is Memorial Compounding Rx (Memorial) entitled to additional reimbursement?

Findings

1. Memorial is seeking reimbursement for drugs dispensed on November 28, 2017. Per explanation of benefits dated December 18, 2017, the insurance carrier denied payment, in part, stating, "the doctor is not authorized to prescribe medication."

   TLC §408.021 (c), "except in an emergency, all health care must be approved or recommended by the employee's treating doctor." No evidence was provided to support that the prescription in question was approved or recommended by the injured employee's treating doctor.

   DWC concludes that no reimbursement can be 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 requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not

entitled to additional reimbursement for the disputed services.

Authorized Signature

		July 13, 2022
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 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. 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 3 or email 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 3 o correo electronico CompConnection@tdi.texas.gov.