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
Zurich American Insurance Co

MFDR Tracking Number
M4-19-0055-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 4, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the reconsideration based on the claim lacks information which is needed for adjudication."

Amount in Dispute: $798.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The issue of medical necessity has been joined, and the disputed services have not yet been determined to be medically necessary and appropriate."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 11, 2017	Compounded Pharmacy Services	$798.06	$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 §134.502 sets out the guidelines for pharmacy services
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The requestor is seeking $798.06 for a compound medication filled on December 11, 2017. The insurance carrier denied disputed services based on lack of information. Review of the submitted documentation found the insurance carrier requested information from the prescribing physician on record on December 5, 2017 and contacted the physician's office by phone on December 8, 2017 to request information.

   28 TAC §134.502 (e) states in pertinent part,

   > The insurance carrier, injured employee, or pharmacist may request a statement of medical necessity from the prescribing doctor. If an insurance carrier requests a statement of medical necessity, the insurance carrier shall provide the sender of the bill a copy of the request at the time the request is made. An insurance carrier shall not request a statement of medical necessity unless in the absence of such a statement the insurance carrier could reasonably support a denial based upon extent of, or relatedness to the compensable injury, or based upon an adverse determination.

   The utilization review notice states, "We have been unable to speak with the provider of record and the clinical information available for our review does not meet preliminary guidelines."

   Based on the above, the insurance carrier's denial is supported. 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

Signature	Medical Fee Dispute Resolution Officer	August 19, 2019 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.