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
M4-19-0084-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
September 7, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Texas labor Code Section 408.027 (b) requires that the carrier must pay, reduce, deny or determine to audit the health provider's claim no later than the 45th day after the date of receipt by the carrier. Memorial did not receive any correspondence as per rule…"

Amount in Dispute: $267.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…Memorial Compounding has failed to provide documentation evidencing it obtained preauthorization for the "N" -drug as required under Division Rule 134.540(b)(1). Accordingly, Carrier has properly denied reimbursement for the medication on the basis it was not preauthorized."

Response Submitted by: Burns Anderson Jury & Brenner LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 13, 2018	Lenzapatch 4%	$267.50	$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 procedures for pharmaceutical benefits.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization

Issues

1. Is the carrier's reason for denial of payment supported?

Findings

1. The requestor is seeking reimbursement of $267.50 for a medication dispensed March 13, 2018. The carrier denied the disputed compound with claim adjustment reason code 197 – "Payment denied/reduced for absence of precertification/authorization."

   For the dates of service in dispute the applicable rule is 28 Texas Administrative Code §134.530(b)(2) which states that preauthorization is **only** required for:

   - drugs identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates;

   Review of the Official Disability Guidelines (ODG), Appendix A found "Lidocaine" under Topical Analgesics is listed as a "N" drug. LenzaPatch: Generic name, (lidocaine & menthol) is a "N" drug and requires preauthorization. The carrier's denial 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

		October 4, 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.