



# 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**

Electric Insurance Co

**MFDR Tracking Number**

M4-19-0539-01

**Carrier's Austin Representative**

Box Number 17

**MFDR Date Received**

October 1, 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 45<sup>th</sup> day after the date of receipt by the carrier. Memorial did not receive any correspondence as per rule..."

**Amount in Dispute:** \$1,167.07

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The compound medication in dispute in this matter and other medications billed were denied based on retrospective medical necessity. The peer review report is attached. The physician did review the medications prescribed and found the medications was not medically necessary."

**Response Submitted by:** Downs Stanford

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 23, 2018	Compounded medication, Lenzapatch, Cyclobenzaprine 10 mg, Gabapentin 300 mg	\$1,167.07	\$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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
- 28 Texas Administrative Code §134.530 sets out prior authorization requirement for pharmacy services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 197 – Payment denied/reduced for absence of precertification/authorization

- P4 – Workers’ compensation claim adjudicated as non-compensable. This payer not liable for claim or service/treatment

**Issues**

1. Have the relevant compensability issues been resolved?

**Findings**

1. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee’s compensable injury. 28 Texas Administrative Code §133.305(b) requires that “If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021.”

The services in dispute were denied, in part, due to unresolved medical necessity issues. The issues raised and relevant to the services in this medical fee dispute involved whether the services provided were medically necessary based on the compensable injury. The disputed services were reviewed for medical necessity on June 14, 2018 and the determination made “the health care services requested does not meet established standards of medical necessity.” The insurance carrier issued a denial on June 28, 2018 indicating non-compensable.

The requestor submitted request for MFDR on October 1, 2018.

Based on the above, the requestor was notified prior to MFDR of the denial based on compensability. No payment can be recommended as the issue of compensability has not been resolved.

**Conclusion**

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

**ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

**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.**