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
Hartford Underwriters Insurance

MFDR Tracking Number
M4-19-0710-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
October 9, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the reconsideration based on not an approved provider."

Amount in Dispute: $569.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Review was previously performed for these medications for DOS 02/05/18. Non-certified determination for these medications. …the request for CMPD: Gabapentin, Amitriptyline, Amantadine, Flurbiprofen, and Bupivacaine topical analgesic is non-certified."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 5, 2018	Compound pharmacy services	$569.93	$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 §134.530 sets out requirements for pharmacy claims not subject to a certified network.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 71 – (No explanation)
   - 197 – Precertification/authorization/notification absent

Issues

1. Is the requestor's position supported?
2. Is the insurance carrier's reason for denial supported?

Findings

1. The requestor is seeking reimbursement for pharmacy compounding service rendered on February 5, 2018. Their position statement is in part, "The carrier denied the reconsideration based on not an approved provider. …Memorial Compounding is an approved provider and should be reimbursed accordingly." Review of the submitted documentation found insufficient evidence to support the requestor's position. Therefore, this statement will not be considered in this review.
2. The insurance carrier denied disputed services based on the lack of preauthorization and states in their position, "…the request for CMPD: Gabapentin, Amitriptyline, Amantadine, Flurbiprofen, and Bupivacaine topical analgesic is non-certified."

   28 TAC §134.530 (g)(2) states,

   > (g) 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.

Review of the submitted documentation found "Notice of Adverse Determination-WC Network" for the services in dispute that states, "…we do not approve these services or treatment."

Further review finds the requestor was notified of this Adverse Determination and the process to appeal this denial.

Based on the above, 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

Signature	Medical Fee Dispute Resolution Officer	June 7, 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.