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
Hartford Underwriters Insurance Co

MFDR Tracking Number
M4-19-1255-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
November 5, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the reconsideration based on lack of preauthorization or preauthorization was absent. These medications do not require preauthorization therefore do not need a retrospective review."

Amount in Dispute: $726.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Review was previously performed for these medications. …there were no indications in the provided documentation that the patient would be unable to tolerate an oral analgesic to sufficiently warrant this request."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 26, 2018	Compounded pharmacy services	$726.32	$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 the guidelines for pharmacy services not subject to certified networks.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization/notification absent

Issues

1. Is the respondent's position statement supported?
2. Did the insurance carrier meet DWC requirements?

Findings

1. The requestor is seeking reimbursement of compounded medication provided on March 26, 2018. In their position statement the requestor states, "These medications do not require preauthorization therefore do not need a retrospective review."

   28 TAC §134.530 (g) states,

   > 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.

   Based on the above the requestor's position is not supported.

2. 28 TAC §134.530 (g) (2) states,

   > 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 a "Notice of Adverse Determination-WC Network" was sent to the requestor that determined, "the services or treatments described below are not medically necessary or appropriate."

   Evidence was found to support that at the time of the medical necessity denial, the requestor was provided with the information on how to appeal this decision.

Based on the above, the requestor was notified the disputed services were not deemed medically necessary or appropriate and therefore not authorized. The insurance carrier's for lack of authorization is supported.

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.