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 Casualty Insurance Co

MFDR Tracking Number
M4-19-1485-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
November 15, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the reconsideration based on not approved provider. Memorial compounding is an approved provider and should be reimbursed accordingly. The referral provider has been treating the patient for the injury sustained at work."

Amount in Dispute: $798.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Sent UR needed letter to MD. Denial issued by ESI to provider."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 28, 2018	Compounded Pharmacy	$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 Pharmaceutical Services
3. 28 Texas Administrative Code §134.530 Pharmacy Claims Not Subject to Certified Networks
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization/notification absent
   - 71 – No explanation

Issues

1. Is the insurance carrier's denial supported?

Findings

1. The requestor is seeking reimbursement of compounded pharmacy services for date of service April 28, 2018 for $798.06.

   28 TAC §134.502 (f) states,

   > The prescribing doctor shall provide a statement of medical necessity to the requesting party no later than the 14th day after receipt of request. The prescribing doctor shall not bill for nor shall the insurance carrier reimburse for the statement of medical necessity.

   Review of the submitted documentation found a request for a statement of medical necessity was made to the prescribing physician on December 4, 2017 for the CMPD: Flurbiprofen, Meloxicam, Mefenamic acid, Baclofen, Bupivacaine, Base. The submitted documentation contained evidence the request was faxed to the prescribing physician successfully.

   Based on the above and the provisions of the rule shown below that allowed for utilization review to done, the insurance carrier's denial is supported.

   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.

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

		June 7, 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.