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
M4-19-1630-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
November 20, 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: $1,065.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The compound medication in dispute in this matter was denied based on retrospective medical necessity."

Response Submitted by: Downs Stanford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 28, 2018	Compounded medication, Lenzapatch	$1065.56	$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 §134.503 sets out the fee guidelines for pharmaceutical services.
3. 28 Texas Administrative Code §134.530 sets out prior authorization requirement for pharmacy services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 39 – Services denied at the time authorization/pre-certification was requested

Issues

1. Is the respondent's position supported?
2. Did the requestor meet requirements of Rule 133.307?

Findings

1. The requestor is seeking reimbursement of Lenzapatch, dispensed on June 28, 2018. The insurance carrier denied the services based on lack of preauthorization.

   28 TAC §134.530(b)(1)(A) states in pertinent part, 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 Appendix A found Lidocaine a component of the Lenzapatch 4% is listed as a "N" drug. The insurance carrier's denial for this medication is supported. No additional payment is recommended.

   The remaining compound consisting of Flurbiprofen, Meloxicam, Mefenamic Acid, Baclofen, Bupivacaine, Ethoxy Diglycol, Versapro Cream were reviewed retrospectively and a report generated October 16, 2018 that found "…There was moreover, no mention of the claimant's having failed anti-depressant adjuvant medications prior to the request I question being initiated. Therefore, the request is not medically necessary."

   The respondents' position of "The compound medication in dispute in this matter was denied based on retrospective medical necessity" is supported.

2. The requestor states in their position, "The carrier has received the attached bill and has not processed according to Texas Labor Code 408.072."

   Review of the submitted documents found the insurance carrier processed the retrospective review on October 19, 2018. An explanation of benefits was sent to Memorial Compounding Pharmacy on October 24, 2018. Memorials' request for MFDR is dated November 5, 2018 where they indicate the carrier has not responded.

   28 TAC §133.307 (N) states in pertinent part,

   a position statement of the disputed issue(s) that shall include:

   (i) the requestor's reasoning for why the disputed fees should be paid or refunded,
   (ii) how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues, and
   (iii) how the submitted documentation supports the requestor's position for each disputed fee issue;

   Based on the above, the requestor has not met the requirements of Rule 133.307. No 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

		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.