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
Trumbull Insurance Co

MFDR Tracking Number
M4-19-2149-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
December 17, 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: $798.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "There is no mention of the disputed medication or any medication in the corresponding office visit notes received with this request. An info letter was faxed to the prescribing doctor… A 2nd letter was faxed with no response. A lack of information letter was then faxed to Dr…"

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 28, 2018	Compound 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 §134.530 sets out requirements for pharmacy claims not subject to certified networks.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 75 – Prior authorization required

Issues

1. Is the requestor's position statement supported?
2. Is the insurance carrier's position supported?

Findings

1. The requestor states in their position statement, "These medications do not require preauthorization therefore do not need a retrospective review." 28 TAC §134.530 (g) states in pertinent parts,

   > (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.

   Based on the above the requestor's position is not supported and will not be considered in this review.

2. The respondent states, "An info letter was faxed to the prescribing doctor… …A 2nd letter was faxed with no response."

   Review of the submitted documentation found a "Drug Information Request" for the service in dispute that asked if medication was related to the claimant's workers compensation injury, for what diagnosis is the medication (s) being prescribed and how is this medication(s) being used in relation to the work injury.

   28 TAC 134.530 (g)(3) states,

   > A prescribing doctor who prescribes pharmaceutical services that exceed, are not recommended, or are not addressed by §137.100 of this title, **is required** to provide documentation upon request in accordance with §134.500(13) of this title (relating to Definitions) and §134.502(e) and (f) of this title

   Based on the above, the respondents' position is supported 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 21, 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.