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**
New Hampshire Insurance Co

**MFDR Tracking Number**
M4-19-2175-01

**Carrier's Austin Representative**
Box Number 19

**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:** "Per First Script review, charges were denied correctly…"

**Response Submitted by:** Gallagher Bassett

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| June 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 §133.250 sets out the requirements for reconsideration.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - July 10, 2018, 50. These are non-covered services because this is not deemed a medical necessity by the payer
   - November 9, 2018. 197 – Precertification/authorization/notification/pre-treatment absent

**Issues**

1. Did the requestor comply with reconsideration guidelines?
2. Is the disputed service eligible for MFDR?

**Findings**

1. The requestor has submitted a request for MFDR for a compound medication dispensed on June 28, 2018. Review of the submitted documentation found a request for reconsideration was submitted for this date of service based on a denial for lack of preauthorization on October 14, 2018.

   28 TAC §133.250 (d) (4) states in pertinent part,

   > A written request for reconsideration shall:
   >
   > (4) include a bill-specific, substantive explanation in accordance with §133.3 of this title (relating to Communication Between Health Care Providers and Insurance Carriers) that provides a rational basis to modify the previous denial or payment

   The explanation given by the health care provider for the reconsideration did not relate to the medical necessity denial of the explanation of benefits dated July 10, 2018. The requestor did not meet the requirements of Rule 133.250.

2. 28 TAC §133.307 (a) (2) states in pertinent parts,

   > (2) In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

   As the services in dispute were deemed as not medically necessary this dispute in not eligible for payment adjudication.

**Conclusion**

For the reasons stated above, DWC 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 | September 6, 2019<br>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**.