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
Zenith Insurance Co

MFDR Tracking Number
M4-19-2211-01

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."

Amount in Dispute: $369.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Claims Examiner has confirmed that the provider failed to obtain a preauthorization for the disputed compound medications. Therefore, no payment is due to the provider."

Response Submitted by: The Zenith

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 28, 2018	Compounded medication	$369.68	$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 sets out the requirements for pharmacy services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 230 – TX Treatment not authorized

Issues

1. Did the submitted medical bill meet requirements of pharmacy claim submission?
2. Did the requestor meet the requirements to submit a MFDR request?

Findings

1. The requestor states in this submitted reconsideration, "After reviewing the explanation of benefits, it indicates that the carrier paid $356.94 and not the full amount of $726.32. 28 TAC §134.502 (d) (2) states in pertinent part,

    Pharmacies and pharmacy processing agents shall submit bills for pharmacy services in accordance with Chapter 133 (relating to General Medical Provisions) and Chapter 134 (relating to Benefits--Guidelines for Medical Services, Charges, and Payments.

    (2) Compound drugs shall be billed by listing each drug included in the compound and calculating the charge for each drug separately.

    Review of the submitted DWC066 finds Meloxicam, Flurbiprofen, Versapro Cream and Compounding fee listed for a total $369.58. This does not match the amount indicated as the "full amount" in the documentation submitted by the requestor of $726.32.

2. 28 TAC 133.307 (2)(J) and (K) states,

    (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include:

    (J) a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions);

    (K) a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB;

    The submitted documentation did not include a copy of the original bill that totaled $726.32 as indicated by the requestor or a copy of the explanation of benefits for the services in dispute. The explanation of benefits submitted by the requestor was a payment of $356.94 for the medications Tramadol, Cyclobenzaprine, Bupivaciane and Ethoxy Diglycol. Based on the above, the requestor failed to meet requirements of Division Rule 134.502 and 133.307. No additional payment can be 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

		July 23, 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.