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
TASB Risk Mgmt Fund

MFDR Tracking Number
M4-19-2351-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
December 21, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial Compounding has following all the requirements to receive the proper reimbursement based on Rule 134.503 Pharmacy Guidelines."

Amount in Dispute: $555.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "A peer review on file indicates that topical compounded medications are not supported by ODG and their use as a first line therapy is not recommended."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 12, 2018	Baclofen, Amantadine, Gabapentin, Bupivacaine, Amitriptyline	$555.68	$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 §134.503 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:
   - 55 – Investigational and experimental
   - 216 – Based on findings of a review organization
   - 197 – Payment adjusted for absence of precertification/authorization

- 114 – Pre-auth is required for any drug identified as investigational or experimental

Issues

1. Is the insurance carrier's reason for denial of payment supported?

Findings

1. 28 TAC 134.530 (b) (1) (C) states,

   (1) Preauthorization is only required for:
   (C) any prescription drug created through compounding prescribed and dispensed on or after July 1, 2018;

   Review of the submitted medical bill finds a date of service July 12, 2018. Insufficient evidence was found to support prior authorization was obtained. 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

		August 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.