TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-19-2494-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
January 10, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the reconsideration based on lack of preauthorization. These medications do not require preauthorization therefore do not need a retrospective review."

Amount in Dispute: $72.69

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester has not fully complied with the requirements of Rule 134.530(b)(i)."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 30, 2018	Promethazine 25 mg	$72.69	$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 §134.540 Requirements for Use of the Closed Formulary for Claims Subject to Certified Networks
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - A11 – Preauthorization required for "N" drugs in ODG Appendix A per Rule 134.503 & 134.504
   - 197 – Precertification/authorization/notification absent

Issues

1. Are the insurance carrier's reasons for denial of payment supported?

Findings

1. The requestor is seeking reimbursement of $72.69 for pharmacy services rendered on August 30, 2018. The insurance carrier denied the disputed services with claim adjustment reason code A11 – "Preauthorization required for "N" drugs in ODG Appendix A per Rule 134.503 & 134.504."

   28 TAC §134.540 states in pertinent part,

   > Preauthorization for claims subject to the Division's closed formulary. Preauthorization is only required for:
   >
   > (1) 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 the ODG Appendix A finds the medication in dispute (Promethazine) is classified as a "N" drug. The carrier's denial 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

		February 8, 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.