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 RX

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-19-2593-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 14, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027."

Amount in Dispute: $555.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The entitlement to medical benefits has been denied on the basis the services are not covered…"

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 5, 2018	Compound Medication	$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 (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Codes §§134.530(b)(1)(B) and (C) set out preauthorization requirements for compounds not subject to certified health care networks.
3. 28 Texas Administrative Code §§134.540(b)(2) and (3) set out preauthorization requirements for compounds subject to certified health care networks.

Issue

Is reimbursement due for the compound in dispute?

Findings

Memorial is seeking reimbursement for a compound dispensed on September 5, 2018. Applicable amended Rule at 28 TAC 134.530[non-network] or 28 TAC 134.540 [network] states, in pertinent part, that preauthorization is required for any prescription drug created through compounding prescribed and dispensed on or after July 1, 2018.

According to the adoption preamble, new section (b)(1)(C) **DOES NOT APPLY** to prescriptions for compounded drugs written before July 1, 2018, and refills for those prescriptions. Therefore, for compounds dispensed on or after July 1, 2018, a copy of the physician's initial prescription is necessary for the DWC to make an informed decision about whether preauthorization is required.

On October 11, 2019, the DWC submitted a request for additional information to Memorial. The request sought "the initial and any subsequent prescription(s) that pertain to the dispensed medications" in dispute. Memorial was given a maximum of 7 days to provide the requested information. Memorial failed to provide the prescription. Therefore, the decision will be based on the information available.

Memorial has failed to provide prescription evidence sufficient to support its assertion that preauthorization was not required. Memorial has therefore failed to meet its burden to prove that reimbursement is due.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that 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 DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	December 20, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.