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
Sentinel Insurance Company Ltd

MFDR Tracking Number
M4-19-2783-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
January 22, 2019

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: $798.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "There has been no office visit notes submitted with this request supporting use of this medication nor is there one on file regarding use of compound meds, thus, an information request letter was faxed to the provider to submit supporting office visit notes for this prescribed compound. There has been no response to the 1st information request letter; 2nd letter was faxed on 12/18/18. There has been no response received from the (2) information request letters faxed to the provider."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 28, 2018	Flurbiprofen, Meloxicam, Mefenamic acid, Baclofen, Bupivacaine, Ethoxy Diglycol, Versapro cream, Compounding fee	$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 §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:
   - 197 – Precertification/authorization/notification absent

Issues

1. Is the respondent's position supported?

Findings

1. The insurance carrier states, "Per protocol medication was denied due to lack of information." 28 TAC §134.502 (e) and (f) stat in pertinent parts,

   (e) The insurance carrier, injured employee, or pharmacist may request a statement of medical necessity from the prescribing doctor. If an insurance carrier requests a statement of medical necessity, the insurance carrier shall provide the sender of the bill a copy of the request at the time the request is made. An insurance carrier shall not request a statement of medical necessity unless in the absence of such a statement the insurance carrier could reasonable support a denial based upon extent of, or relatedness to the compensable injury, or based upon an adverse determination.

   (f) The prescribing doctor shall provide a statement of medical necessity to the requesting party no later than the 14th day after receipt of request. The prescribing doctor shall not bill for nor shall the insurance carrier reimburse for statement of medical necessity.

   Review of the submitted documentation found the insurance carrier supported their statement of requesting additional documentation to support the medical necessity of the services in dispute but received no documentation. The respondent's position 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

	Peggy Miller	August 30, 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.