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
Texas Mutual Insurance

MFDR Tracking Number
M4-19-5203-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 15, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...Memorial compound pharmacy has met the requirements to receive reimbursement."

Amount in Dispute: $320.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the carrier maintains its position of the denial as preauthorization was not obtained."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 22, 2019	Diclofenac	$320.60	$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 §134.530 sets out the billing 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
   - 193 – Original payment decision is being maintained

Issues

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

Findings

1. The insurance carrier denied disputed services based on lack of preauthorization. 28 TAC §134.530 (1)(A) requires 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 Appendix A found the service in dispute, Diclofenac is listed as a "N" in topical form. Insufficient evidence was found to support the health care provider received preauthorization for the services in dispute. The insurance carrier's denial is supported. No payment is recommended.

Conclusion

For the reasons stated above, DWC 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, DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		September 25, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.