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
Amerisure Insurance Company

MFDR Tracking Number
M4-18-0606-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
November 6, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The original bill was submitted to carrier on 06/9/2017 … Memorial did not receive any correspondence as per rule so we submitted a Request for Reconsideration … The request was submitted and received by the carrier on 09/2/2017 still with no response."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has paid these dates of service in full…"

Response Submitted by: Amerisure Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 27, 2017	Pharmacy Service – Compound	$150.00	$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. The submitted documentation does not include explanations of benefits.

Issues

1. Did Amerisure Insurance Company (Amerisure) make a payment for the compound in question?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the compound in question?

Findings

1. Labor Code Sec. 408.027 (b), and corresponding 28 Texas Administrative Code (TAC) §133.240 define the insurance carrier's responsibility when reviewing a medical bill for reimbursement. Amerisure was required to take final action by paying, reducing or denying the disputed services within 45 days after it received the complete medical bill in the manner prescribed by Rule §133.240.

   TAC §133.240 (e) allows the carrier to provide either an electronic remit, or a paper explanation of benefits to the billing health care provider as a means of communicating payment of a medical bill. In its position statement, Amerisure stated, "The Carrier has paid these dates of service in full…"

   Review of the documentation submitted to the division does not find an explanation of benefits in accordance with TAC §133.240 (e). Amerisure failed to support that a payment was made for the compound in question.

2. Documentation presented to the division indicates that the billed charges constitute a compound drug. 28 Texas Administrative Code §134.502(d)(2) requires that compounds to "be billed by listing each drug included in the compound and calculating the charge for each drug separately."

   The submitted documentation does not support that Memorial listed each drug in the disputed compound, calculating the charge for each drug separately. Therefore, the division concludes that Memorial is not eligible for reimbursement of the compound in question.

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

	Laurie Garnes	February 1, 2018
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.