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
Amerisure Mutual Insurance Co

MFDR Tracking Number
M4-18-0770-01

Carrier's Austin Representative
Box 47

MFDR Date Received
November 20, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial did not receive any correspondence as per rule so we submitted a Request for Reconsideration...As of today, we still haven't received any correspondences."

Amount in Dispute: $479.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Amerisure has issued a check...in the amount of $479.89."

Response Submitted by: Amerisure Insurance

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
May 28, 2017	Prescription Medication	$479.89	$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 reimbursement for compound medications
3. Correspondence Letters Sent to Memorial Compounding

   Letter Dated July 17, 2017
   - Date of Service 05/28/2017...38779237601 is not a valid NDC #

   Letter Dated August 30, 2017
   - Date of Service 05/28/2017...38779237601 is not a valid NDC code

   Letter Dated November 9, 2017
   - Date of Service 05/28/2017...38779237601 NDC # is invalid

Findings

The Division makes the following conclusions based upon the information and documentation presented to the Division to date. Even though all the evidence was not discussed, it was considered.

1. *Did the carrier make a payment for the disputed services?*

Memorial Compounding Rx (Memorial) asserts that it billed the carrier for the service in dispute, but did not receive any response from the carrier. Documentation provided by the carrier indicates that it responded to Memorial compounding in July, August and November of 2017 indicating that the NDC number on the bill for the disputed services was not valid. Review of the FDA National Drug Code Directory find that the NDC number reported by Memorial on its billing is indeed invalid.

Despite the fact that the NDC number reported by Memorial for the service in dispute was invalid, the carrier went ahead and issued a payment in the amount of $479.89 to Memorial Compounding Pharmacy on December 5, 2017.

Although the Division's medical fee dispute resolution program notified Memorial of the payment, Memorial has not taken the opportunity to refute that the carrier has paid the disputed amount, nor has Memorial provided additional information to date.

For that reasons, the Division moves to resolve this dispute with the information available and concludes that no additional reimbursement can be recommended.

Conclusion

The Division concludes that Memorial has already been paid for the $479.89 in dispute. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, and pursuant to Texas Labor Code Section 413.031, the division has determined that the requestor is not entitled to additional reimbursement for the services in dispute.

_____ _____ January 31, 2018

Medical Fee Dispute Resolution Director Date

RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 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 with the Division. **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.