



# 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**

TASB Risk Management Fund

**MFDR Tracking Number**

M4-18-4052-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

June 21, 2018

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "These medications do not require preauthorization therefore do not need a retrospective review ... Memorial Compounding Pharmacy is not register as an outsourcing facility. Therefore 503A applies and exempts the compounding cream in dispute."

**Amount in Dispute:** \$489.98

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "No letter of medical necessity or other supporting documentation has been submitted as requested ... TASB-RMF considers any treatment that is not specifically cited, discussed, and approved in the current version of ODG, or is not FDA approved for the specific condition being treated, as being investigational or experimental."

**Response Submitted by:** TASB Risk Management Fund

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 30, 2017	Tramadol 100%	\$489.98	\$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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- The insurance carrier denied payment based on the following claim adjustment reason codes:
  - 151 – Payment adjusted because the payer deems the information submitted does not support this

- many services.
- Notes: "Provide letter of medical necessity for powder versus pill form."
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – Additional payment made on appeal/reconsideration.
- Notes: "Rule 134.804 (a) Services reviewed for reconsideration. Additional payment made or service adjustment amount may be zero."
- Notes: "Per Rule 134.530 Pre-auth is required for any drug identified as investigational or experimental for which there is early developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined by labor code 413.014."
- Notes: "The compound product is not used in an approved FDA form & not approved by the FDA."
- Notes: "Peer review by Dr. David T. Schroder, MD on file."

**Issues**

Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement?

**Findings**

Memorial submitted documentation stating that the billed charges constitute a compound drug. Compound bills are required to list each drug in the compound and calculating the charge for each drug separately.<sup>1</sup>

The submitted documentation does not support that Memorial listed each drug in the disputed compound, calculating the charge for each drug separately. Therefore, 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	November 30, 2018
Signature	Medical Fee Dispute Resolution Officer	Date

<sup>1</sup> 28 Texas Administrative Code §134.502(d)(2)

### ***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.**