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
M4-18-4186-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
July 2, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "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: "A letter of medical necessity for the use of powder formula instead of pill form was requested."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 25, 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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier denied payment based on lack of information.

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.[1]

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	April 29, 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.

[1] 28 Texas Administrative Code §134.502(d)(2)