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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MERKEL DRUG COMPANY
121 EDWARDS
MERKET TX 79536

Respondent Name
AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-1900-01

MFDR Date Received
FEBRUARY 2, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary with the request for medical fee dispute resolution.

Amount in Dispute: $223.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This medical dispute concerns reimbursement for medications the requestor allegedly provided to the claimant between February 14, 2011 and August 25, 2011. The carrier has no record of receiving the bills for the medications until December 13, 2011, which is more than ninety-five days from the dates of service for the disputed bills. A provider must submit a bill within ninety-five days of the date the service was provided. Because the requestor has failed to provide any convincing evidence that it timely submitted its bills for payment, or ever requested reconsideration of the bills in question, the requestor is not entitled to any reimbursement."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 14, 2011 February 25, 2011 March 18, 2011 April 25, 2011 August 25, 2011	HYDROCODONE-APAP 7.25-500 HYDROCODONE-APAP 7.25-325 HYDOROCODONE-APAP 5-325 TA HYDOROCONE-APAP 5-325 TA DOXYCYCLINE HYCLATE 50MG	$223.44	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 a medical fee dispute.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - EOB's were not submitted by either party.

Issues

1. Was a request for reconsideration made for the dispute dates of service?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.307(2)(A) and (B) the provider shall complete the required sections of the request in the form and manner prescribed by the Division. The provider shall file the request with the MDR Section by any mail service or personal delivery. The request shall include: (A) a copy of all medical bill(s), in a paper billing format using an appropriate DWC approved paper billing format, as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills) and (B) a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB. Review of the documentation provided by both parties does not contain evidence to support a request for reconsideration was made by the requestor. Furthermore, review of the DWC066, Statement of Pharmacy Services, shows that Box 2 in the General Information section does not contain a billing date.
2. The requestor in this medical fee dispute has the burden to prove that it is due reimbursement. No evidence was found to support a request for reconsideration was made. For that reason, the Division concludes that the requestor has failed to prove that a request for reconsideration was made and that reimbursement is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that no reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services..

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 28, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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