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
Eng's Pharmacy

Respondent Name
American Zurich Insurance Company

MFDR Tracking Number
M4-14-3092-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 10, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… An EOB was received on 03/04/2014 … However, we have not yet received the payment."

Amount in Dispute: $170.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This is a medical fee dispute concerning charges for prescriptions for hydrocodone and tizanidine hcl on 1/29/2014. An EOB dated 2/19/2014 indicates approval of the billed amounts $56.49 and $113.30."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 29, 2014	Prescription Medication (Hydrocodone & Tizanidine HCl)	$170.40	$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 reduced payment for the disputed services with the following claim adjustment codes: No denial or reduction of charges.

Issues

Is the requestor entitled to additional reimbursement?

Findings

The requestor is seeking reimbursement for prescription medications hydrocodone and tizanidine HCl, date of service January 29, 2014. Review of the submitted documentation finds that the insurance carrier presented an explanation of benefits for these services authorizing full payment of the billed amount. Further, documentation provided supports that payment was issued to the requestor for the services in question on March 6, 2014. Therefore, no further reimbursement is recommended.

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 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

	Laurie Garnes	October 9, 2015
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 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.