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
American Zurich Insurance Company

MFDR Tracking Number
M4-19-0402-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 25, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027."

Amount in Dispute: $357.31

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The issue of extent of injury and relatedness has been joined … Memorial should send its bill directly to the PBM … In this case, Memorial dropped the bill to paper and sent directly to the Carrier."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 17, 2018	Gabapentin 300 mg Capsules	$137.34	$103.80
April 17, 2018	Tizanidine HCl 4 mg Tablets	$145.41	$113.89
April 17, 2018	Acetaminophen/Codeine #3 Tablets	$74.56	$25.33
	Total	$357.31	$243.02

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 for the disputed drugs based on extent of the compensable injury.

Issues

1. Is this dispute subject to dismissal based on extent of injury?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drugs in question?

Findings

1. The insurance carrier processed the bill in question and denied the compound based on extent of the compensable injury. A dispute regarding extent of injury must be resolved prior to a request for medical fee dispute.[1]

   The respondent is required to attach a copy of any related Plain Language Notice (PLN) if the medical fee dispute involves compensability or liability. Review of the submitted documentation finds that Flahive, Ogden & Latson failed to attach a copy of a related PLN on behalf of the insurance carrier to support a denial based on extent of the compensable injury.

2. Because the insurance carrier failed to support its denial of payment, Memorial is entitled to reimbursement for the drug in question.

   The reimbursement considered in this dispute is calculated as follows[2]:

   - Gabapentin 300 mg capsules: (1.3307 x 60 x 1.25) + $4.00 = $103.80
   - Tizanidine HCl 4 mg tablets: (1.46524 x 60 x 1.25) + $4.00 = $113.89
   - Acetaminophen/Codeine #3 tablets: (0.28435 x 60 x 1.25) + $4.00 = $25.33

   The total reimbursement is therefore $243.02. This amount is recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $243.02.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor $243.02, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	August 29, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 Texas Administrative Codes §§133.305(b) and 133.307(c)(1)(B)(i)

[2] 28 Texas Administrative Code §134.503(c)

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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.