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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
American Zurich Insurance Company

MFDR Tracking Number
M4-19-2291-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 20, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Bill for date of service **06/26/2018** was denied for unresolved issues of extent of injury. A call was placed to carrier to confirm patient demographics as well as compensability. We were not notified of any disputes or PLN11 filed."

Amount in Dispute: $563.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was initially disputed based upon entitlement to benefits or extent of injury. The Carrier notified the Requestor of the dispute in its EOBs, as required by rule."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 26, 2018	Meloxicam 7.5 mg Tablets	$247.62	$241.65
June 26, 2018	Omeprazole DR 20 mg Capsules	$315.51	$315.51
	Total	$563.13	$557.16

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. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical benefits.
3. The insurance carrier denied payment for the disputed drugs based on the extent of the compensable injury.

Issues

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

Findings

1. Memorial is seeking reimbursement for drugs dispensed on June 26, 2018. The insurance carrier denied the disputed drugs based on the 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 extent of injury. Review of the submitted documentation finds that American Zurich Insurance Company failed to provide a copy of a related PLN to the division to support a denial based on the extent of the compensable injury.

   Therefore, the dispute considered here is not subject to dismissal based on this denial reason.

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

   The reimbursement considered in this dispute is calculated in accordance with 28 Texas Administrative Code §134.503(c) as follows:

   - Meloxicam 7.5 mg Tablets: (3.1687 x 60 x 1.25) + $4.00 = $241.65
   - Omeprazole DR 20 mg Capsules: (4.3002 x 60 x 1.25) + $4.00 = $326.52
     Memorial is seeking $315.51 for this drug. This amount is recommended.

   The total reimbursement is therefore $557.16. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $557.16.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $557.16, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	April 26, 2019 Date

[1] 28 Texas Administrative Codes § 133.307(d)(2)(H)

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.