



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

Zurich American Insurance Company

MFDR Tracking Number

M4-19-3105-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

February 12, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It looks like the carrier processed the claim but never issued a payment to our facility."

Amount in Dispute: \$532.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "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
August 31, 2018	Tramadol HCl 50 mg Tablets	\$107.78	\$66.85
August 31, 2018	Zolpidem Tartrate 10 mg Tablets	\$196.25	\$177.44
August 31, 2018	Cyclobenzaprine 10 mg Tablets	\$123.02	\$85.90
August 31, 2018	Ibuprofen 800 mg Tablets	\$105.79	\$64.37
Total		\$532.84	\$394.56

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

- 28 Texas Administrative Code §133.260 sets out the procedures for requests for refunds.
- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- 18 – Exact duplicate claim/service

Issues

1. Is the insurance carrier’s reason for denial of payment supported?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drug in question?

Findings

1. Memorial is seeking reimbursement for drugs dispensed on August 31, 2018. The insurance carrier denied the drug as a duplicate service.

Zurich American Insurance Company denied the drugs based on “Exact duplicate claim/service.” The insurance carrier failed to support that these charges were duplicated from another bill. This denial reason is, therefore, not supported.

The DWC finds that the denial of payment for the drug in question is not supported.

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 follows¹:

- Tramadol HCl 50 mg tablets: $(0.838 \times 60 \times 1.25) + \$4.00 = \$66.85$
- Zolpidem Tartrate 10 mg tablets: $(4.6251 \times 30 \times 1.25) + \$4.00 = \$177.44$
- Cyclobenzaprine 10 mg tablets: $(1.092 \times 60 \times 1.25) + \$4.00 = \$85.90$
- Ibuprofen 800 mg tablets: $(0.8049 \times 60 \times 1.25) + \$4.00 = \$64.37$

The total reimbursement is therefore \$394.56. 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 \$394.56.

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 \$394.56, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	April 3, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

¹ 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 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.