



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

M4-19-4113-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

May 13, 2019

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: \$362.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has not been able to locate the documentation related to this bill submission and will file a supplemental response upon completion of that investigation."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 4, 2019	Ibuprofen 800 mg Tablets	\$107.53	\$66.44
February 4, 2019	Tizanidine HCL 4 mg Tablets	\$145.41	\$113.89
February 4, 2019	Hydrocodone/APAP 5-325 Tablets	\$109.36	\$68.83
Total		\$362.30	\$249.16

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 (DWC).

Background

1. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. The submitted documentation does not include explanations of benefits.

Issues

1. Did the insurance carrier take final action on the bill for the service in question prior to the request for medical fee dispute resolution (MFDR)?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drugs in question?

Findings

1. Memorial is seeking reimbursement for drugs dispensed on February 4, 2019. Memorial stated that

The original bill was submitted to carrier on **02/14/2019 via certified mail** ... Memorial did not receive any correspondence as per rule so we submitted a Request for Reconsideration ... The request was submitted and received by the carrier on **04/05/2019 via certified mail** still with no response.

The insurance carrier is required to take final action by paying, reducing, or denying the service in question not later than 45 days after receiving the medical bill. This deadline is not extended by a request for additional information.¹

The greater weight of evidence presented to the DWC supports that a complete bill for the services in question was received by the insurance carrier or its agent. No evidence was provided to support that the insurance carrier took final action on the bill for the service in question.

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

The reimbursement considered in this dispute is calculated as follows²:

- Ibuprofen 800 mg tablets: $(0.8339 \times 60 \times 1.25) + \$4.00 = \$66.54$
- Tizanidine HCl 4 mg tablets: $(1.46524 \times 60 \times 1.25) + \$4.00 = \$113.89$
- Hydrocodone-APAP 5-325 tablets: $(0.69154 \times 75 \times 1.25) + \$4.00 = \$68.83$

The total reimbursement is therefore \$249.16. This amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that reimbursement is due for the drugs in question. As a result, the amount ordered is \$249.16.

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 \$249.16, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	October 4, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

¹ 28 Texas Administrative Code §133.240(a)

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.