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 RX

Respondent Name
Zurich American Insurance Company

MFDR Tracking Number
M4-20-0433-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 18, 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: $426.77

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "While Memorial claims it received no response to this bill, the bill was paid long before Memorial filed its DWC-60."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 11, 2019	Cyclobenzaprine 10 mg Tablets	$122.99	$85.86
July 11, 2019	Zolpidem Tartrate 10 mg Tablets	$196.25	$177.44
July 11, 2019	Ibuprofen 800 mg Tablets	$107.53	$66.54
	Total	$426.77	$329.84

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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.

Issues

Is Memorial Compounding Rx (Memorial) entitled to reimbursement of the drugs in question?

Findings

Memorial wants reimbursement for drugs dispensed on June 11, 2019. Memorial argued that it had not gotten a response from the insurance carrier for its bills.

Flahive, Ogden & Latson submitted an explanation of benefits (EOB), dated September 9, 2019. This EOB is labeled as a reconsideration and shows a total payment of $0.00, citing denial of additional money based on fee guidelines.

The DWC requested an initial EOB on November 14, 2019. The insurance carrier and its representative failed to provide the additional information.

Based on the available information, the DWC finds that Memorial is entitled to reimbursement for the drugs in question. The reimbursement considered in this dispute is calculated as follows[1]:

- Cyclobenzaprine 10 mg tablets: (1.0915 x 60 x 1.25) + $4.00 = $85.86
- Zolpidem Tartrate 10 mg tablets: (4.6251 x 30 x 1.25) + $4.00 = $177.44
- Ibuprofen 800 mg tablets: (0.8339 x 60 x 1.25) + $4.00 = $66.54

The total reimbursement is $329.84. This amount is recommended.

Conclusion

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 $329.84.

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 $329.84, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	December 13, 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 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.