



# 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**

American Zurich Insurance Company

**MFDR Tracking Number**

M4-20-0837-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

December 5, 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:** \$168.18

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "This bill was paid. See attached EOB."

**Response Submitted by:** Flahive, Ogden & Latson

### SUMMARY OF FINDINGS

| Dates of Service | Disputed Services          | Amount In Dispute | Amount Due |
|------------------|----------------------------|-------------------|------------|
| August 14, 2019  | Tramadol HCl 50 mg Tablets | \$77.41           | \$28.88    |
| August 14, 2019  | Gabapentin 300 mg Capsules | \$90.77           | \$45.58    |
|                  | Total                      | \$168.18          | \$74.46    |

### 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**

- 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.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies
  - HSB3 – Duplicate Paid/Captured Claim

**Issues**

1. Is American Zurich Insurance Company’s denial of payment supported?
2. Is Memorial Compounding Rx (Memorial) entitled to reimbursement for the drugs in question?

**Findings**

1. Memorial is seeking reimbursement for drugs dispensed on August 14, 2019. Flahive, Ogden & Latson argued that the bill was paid.

In the submitted explanation of benefits dated October 23, 2019, American Zurich Insurance Company denied payment based on duplicate billing.

No evidence was submitted to support that this bill was a duplicate or that it was paid.

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 follows<sup>1</sup>:

- Tramadol HCl 50 mg tablets:  $(0.79615 \times 25 \times 1.25) + \$4.00 = \$28.88$
- Gabapentin 300 mg capsules:  $(1.3307 \times 25 \times 1.25) + \$4.00 = \$45.58$

The total allowable reimbursement is \$74.46. 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 \$74.46.

***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 \$74.46, 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

February 6, 2020  
Date

<sup>1</sup> 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.**