



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 CO

MFDR Tracking Number

M4-20-1188-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

January 13, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The above claimant received medication as prescribed by referral provider. Bill for date of service **09/24/2019** was processed and paid incorrectly."

Amount in Dispute: \$446.93

RESPONDENT'S POSITION SUMMARY

Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 24, 2019	Zolpidem Tartrate 10 mg Tablets	\$196.26	\$177.45
September 24, 2019	Tramadol HCl 50 mg Tablets	\$105.27	\$63.71
September 24, 2019	Tizanidine HCl 4 mg Tablets	\$145.40	\$113.88
Total		\$446.93	\$355.04

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 §133.240 sets out the procedures for payment, reduction, or denial of medical bills.
- 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 submitted documentation does not include explanations of benefits for the drugs in question.

Issues

1. Did American Zurich Insurance Company respond to the medical fee dispute?
2. Is Memorial Compounding Rx (Memorial) entitled to additional reimbursement?

Findings

1. The Austin carrier representative for American Zurich Insurance Company is Flahive Ogden & Latson. The representative was notified of this medical fee dispute on January 22, 2020. If the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.¹

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

2. Memorial is seeking reimbursement for drugs dispensed on September 24, 2019. The documentation presented does not include a denial or reduction reason for the drugs in question.

Because American Zurich Insurance Company failed to support any denial reason for the drugs in this dispute, the DWC finds that Memorial is entitled to reimbursement.

The reimbursement considered in this dispute is calculated as follows²:

- Zolpidem Tartrate 10 mg tablets: $(4.6254 \times 30 \times 1.25) + \$4.00 = \$177.45$
- Tramadol HCl 50 mg tablets: $(0.79615 \times 60 \times 1.25) + \$4.00 = \$63.71$
- Tizanidine HCl 4 mg tablets: $(1.465 \times 60 \times 1.25) + \$4.00 = \$113.88$

The total allowable reimbursement is \$355.04. 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 \$355.04.

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 \$355.04, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		June 4, 2020
Signature	Medical Fee Dispute Resolution Officer	Date

¹ 28 TAC §133.307(d)(1)
² 28 TAC §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.