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
M4-20-1229-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 17, 2020

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: $88.29

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier's records show 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
September 24, 2019	Ibuprofen 400 mg Tablets	$88.29	$42.48

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 a medical bill.
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.

Issues

Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drugs in question?

Findings

Memorial is seeking reimbursement for drugs dispensed on September 24, 2019. In its position statement, Flahive, Ogden & Latson argued on behalf of the insurance carrier that the bill was paid. The DWC reviewed the submitted documents.

The insurance carrier submitted a document dated December 16, 2019, as evidence of payment. This document indicates that the review agent recommended payment of $42.49 and then reversed that payment in the same document. No codes were provided to support a denial of payment for the drugs in dispute.

Based on the documentation provided, the DWC finds that there is insufficient evidence that the insurance carrier reimbursed the drugs in question or provided a reason for denial as required by 28 TAC §133.240(f).

Because the insurance carrier failed to sufficiently support a denial of reimbursement or that the bill was paid, Memorial is entitled to reimbursement.

The reimbursement considered in this dispute is calculated as follows[1]:

- Ibuprofen 400 mg tablets: (0.34208 x 90 x 1.25) + $4.00 = $42.48

The total allowable reimbursement is $42.48. 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 $42.48.

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 $42.48, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	March 5, 2020
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.