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 CO

MFDR Tracking Number
M4-20-2675-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 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 03/10/2020 still has not been processed by carrier. All bills are required to be processed within 45 days of receipts by the carrier as per Texas Labor Code 408.027(b) Memorial Compounding Pharmacy has not received any correspondence with explanation of review or benefits."

Amount in Dispute: $981.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier believes this bill has been processed, and is awaiting documentation from the vendor. The Carrier will supplement this response upon completion of its investigation."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 10, 2020	Hydrocodone Apap	$145.53	$546.14
	Tramadol HCL	$105.24	
	Doxycycline Hyclate	$389.43	
	Zolpidem Tartrate	$196.26	
	Tizandine HCL	$145.41	

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.

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

1. What rule(s) apply to disputed services?

Findings

The requestor is seeking reimbursement for oral medication dispensed March 10, 2020. The insurance company provided no evidence of adjudication. The service in dispute will be reviewed per applicable fee guideline. 28 Texas Administrative Code §134.503 (c) states the insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:

• Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

• Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Hydrocodone/Apap	00603-3887-28	G	$0.98	30	$36.68	$145.53	$36.68
Tramadol HCL	57664-0377-18	G	$0.80	30	$29.86	$105.27	$29.86
Doxyclycline Hyclate	00143-9803-05	G	$5.53	30	$207.46	$196.26	$196.26
Zolpidem Tartrate	13668-0008-05	G	$4.63	30	$173.45	$196.26	$173.45
Tizandidine HCL	29300-0169-10	G	$1.47	60	$109.89	$145.41	$109.89
						Total	$546.14

The total reimbursement is $546.14. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $546.14.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $546.14, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

[redacted]	[redacted]	October 14, 2020
Signature	Medical Fee Dispute Resolution Officer	Date

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 division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division 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.