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

Requester Name
MEMORIAL COMPOUNDING RX

Respondent Name
AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number
M4-21-0014-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 4, 2020

REQUESTER'S POSITION SUMMARY

"The Explanation of Benefits indicated that the original was **ILLEGIBLE**. In fact, the entirety of the bill is computer generated and completely free of any manual handwriting. With a bill created entirely by computer typed text, it is not a possibility for any of the content to be unclear or illegible, please see attached original bill for reference."

Amount in Dispute: $561.66

RESPONDENT'S POSITION SUMMARY

"The Carrier has not been able to locate the documents relevant to this bill and is working with its bill review vendor to locate that documentation. The Carrier will supplement this bill upon completion of its investigation."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 10, 2020	Diclofenac Sodium 1% Gel	$320.60	$320.60
June 10, 2020	Metaxalone 800 mg Tablets	$147.34	$116.30
June 10, 2020	Ibuprofen 800 mg Tablets	$93.72	$49.28
	Total	$561.66	$486.18

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.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - SLGB – Illegible billing submitted. Please provide a clear copy of the billing form along with required documentation.

Issues

1. Is the American Zurich Insurance Company's reason for denial of payment supported?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement?

Findings

1. Memorial is seeking reimbursement for drugs dispensed on June 10, 2020. American Zurich denied payment based on an illegible bill. The insurance carrier provided no evidence to support this denial reason[1].
2. The greater weight of evidence presented to the DWC supports that a complete bill for the services in question was received by the insurance carrier or its agent. Therefore, the DWC finds that Memorial is entitled to reimbursement for the drugs in question.

   The reimbursement considered in this dispute is calculated as follows[2]:

   - Diclofenac Sodium 1% Gel: (0.5262 x 500 x 1.25) + $4.00 = $332.88
     Memorial is seeking $320.60 for this drug. No additional reimbursement is recommended.
   - Metaxalone 800 mg tablets: (5.9895 x 15 x 1.25) + $4.00 = $116.30
   - Ibuprofen 800 mg tablets: (0.8049 x 45 x 1.25) + $4.00 = $49.28

   The total allowable reimbursement is $486.18. This amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requester has established that additional reimbursement is due. As a result, the amount ordered is $486.18.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requester is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requester $486.18, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 17, 2020 Date

[1] 28 TAC §133.307 (d)(2)
[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.