



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

M4-21-0071-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

September 15, 2020

REQUESTER'S POSITION SUMMARY

"Memorial Compounding Pharmacy has met the requirements to receive reimbursement."

Amount in Dispute: \$200.37

RESPONDENT'S POSITION SUMMARY

"The Carrier understands this bill was denied for reason the treatment was for non-covered (unrelated) diagnoses..."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 11, 2020	Diclofenac Sodium 1% Gel	\$110.12	\$69.78
June 11, 2020	Cyclobenzaprine 10 mg Tablets	\$90.25	\$44.93
	Total	\$200.37	\$114.71

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:
 - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
 - P12 – Workers' compensation jurisdictional fee schedule adjustment.
 - 60 – The provider has billed for the exact services on a previous bill.

- ZR – The provider or a different provider has billed for the exact service on a previous bill where no allowance was originally recommended.

Issues

1. Did American Zurich Insurance Company raise a new defense in its response?
2. Are the insurance carrier’s reasons for denial of payment for the drugs in question supported?
3. Is Memorial Compounding Rx (Memorial) entitled to additional reimbursement?

Findings

1. In its position statement, Flahive, Ogden & Latson, on behalf of American Zurich Insurance Company, argued that “this bill was denied for reason the treatment was for non-covered (unrelated) diagnoses.”

The response from the insurance carrier is required to address only the denial reasons presented to the health care provider before to the request for medical fee dispute resolution (MFDR) was filed with the DWC. Any new denial reasons or defenses raised shall not be considered in this review.¹

The submitted documentation does not support that a denial based on relatedness was provided to Memorial before this request for MFDR was filed. Therefore, the DWC will not consider this argument in the current dispute review.

2. Memorial is seeking reimbursement for drugs dispensed on June 11, 2020. The insurance carrier denied payment based on previous payment or denial of payment to Memorial or another provider for the services in question. No evidence was provided that these drugs were previously paid or denied. The insurance carrier failed to support its denial of payment.
3. Because American Zurich Insurance Company failed to support its denial reason for the service in this dispute, the DWC finds that Memorial is entitled to reimbursement.

The reimbursement considered in this dispute is calculated as follows²:

- Diclofenac sodium 1% gel: $(0.5262 \times 100 \times 1.25) + \$4.00 = \$69.78$
- Cyclobenzaprine HCl 10 mg tablets: $(1.0915 \times 30 \times 1.25) + \$4.00 = \$44.93$

The total allowable reimbursement is \$114.71. 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 \$114.71.

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 \$114.71, 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	October 20, 2020 Date
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¹ 28 TAC §133.307 (d)(2)(F)
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.