TDI Division of Workers' Compensation

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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
M4-22-1442-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
March 15, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 2, 2021	Prescribed Medication	$691.97	$623.63
	Total	$691.97	$623.63

Requestor's Position

"Reimbursement should be made to the provider if the claim has been submitted within the 95th day after the date on which the health care service was rendered. The original bill was submitted to carrier on 12/06/2021 via certified email… The request was submitted and received by the carrier on 01/19/2022 via certified email still with no response. I have attached proof of submission for both correspondences. The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027."

Amount in Dispute: $691.97

Respondent's Position

"The Carrier prevailed in an extent of injury dispute, is not responsible for the billed services, and MFDR has no jurisdiction to determine any fee amount due."

Response Submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

This medical fee dispute is decided according 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 (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.503 sets out the fee guidelines for pharmaceutical services.

Denial Reasons

Neither party submitted an explanation of benefits for the disputed services.

Issues

1. Is the insurance carrier's denial reason supported?
2. What rules apply to disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for prescribed medication dispensed on December 2, 2021. The insurance carrier states, "The Carrier prevailed in an extent of injury dispute, is not responsible for the billed services, and MFDR has no jurisdiction to determine any fee amount due."

   Neither party submitted EOBs with the DWC060 request/response. The requestor submitted sufficient documentation to support that the provisions of 28 TAC §133.307 (c)(2)(K) were met.

   The insurance carrier did not submit documentation to support the rationale indicated in the position summary, no EOBs or copies of CCH or Appeals panel decisions were provided for review to support their position. As a result, due to the insufficient documentation and pursuant to 28 TAC 133.307 (d)(2)(B) and (d)(2)(D) the DWC will proceed with the audit of the disputed charges.

2. The service in dispute will be reviewed per applicable fee guideline. DWC Rule 28 TAC §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

Drug	NDC	Generic (G)	Quantity	AWP /unit	DWC Fee	Billed Amount	Lesser of DWC Fee and Billed Amount
Acetaminophen/Cod	00406048505	G	60	0.93670	$74.25	$113.70	$74.25
Eszopiclone 3 mg	33342030111	G	30	12.16130	$460.05	$422.34	$422.34
Cyclobenzaprine 5 mg	52817033050	G	60	1.64050	$127.04	$155.93	$127.04
TOTAL			150		$661.34	$691.97	$623.63

3. The DWC finds that the requestor, is entitled to reimbursement, in the amount of $623.63.

Conclusion

The outcome of each independent medical fee dispute relies on the relevant evidence the requester and respondent present at the time of adjudication. Although all the evidence in this dispute may not have been discussed, it was considered.

The DWC finds the requester has established that reimbursement is due. As a result, the amount ordered is $623.63.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that the respondent must remit to the Requester $623.63 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 25, 2022 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252- 7031, Option 3, or email CompConnection@tdi.texas.gov. The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.