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 Pharmacy

Respondent Name
North River Insurance Co

MFDR Tracking Number
M4-19-4983-01

Carrier's Austin Representative
Box Number 3

MFDR Date Received
July 25, 2019

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: $63.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No response submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 24, 2019	Acetaminophen/Cod	$63.19	$7.10

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 is the applicate fee calculation for the service in dispute?

Findings

The Austin carrier representative for North River Insurance is Hoffman Kelley who acknowledged receipt of the copy of this medical fee dispute on August 1, 2019. 28 TAC §133.307 states, in relevant part:

(d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
(1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

Review of the documentation finds that no response has been received on behalf of the insurance carrier from the carrier representative to date. DWC will base its decision on the information available.

1. The requestor is seeking reimbursement of $63.19 for an oral medication dispensed on April 24, 2019. The insurance carrier did not submit a position statement nor was any evidence of payment or denial submitted with this request.

   28 TAC §134.503 (c) details the fee is 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:

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

The calculation based on the above is below.

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Acetaminophen /Codeine	00093015010	G	$0.28	20	$7.10	$63.19	$7.10
						Total	$7.10

The total reimbursement is $7.10. 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 $7.10.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), DWC has determined the requestor is entitled to additional reimbursement for the disputed services.
DWC hereby ORDERS the respondent to remit to the requestor $7.10, plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 9, 2019 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to 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 TAC §141.1(d).

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