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
OLD REPUBLIC INSURANCE CO

MFDR Tracking Number
M4-20-0839-01

Carrier's Austin Representative
Box 44

MFDR Date Received
DECEMBER 5, 2019

REQUESTOR'S POSITION SUMMARY

"The above claimant received medication and the carrier still has not acknowledged receipt of service."

Amount in Dispute: $93.91

RESPONDENT'S POSITION SUMMARY

No response received.

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
August 1, 2019	Pharmacy Services Prescription Drug 49483-0618-50	$93.91	$49.50

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 (TAC) §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes
2. 28 TAC §134.503, effective October 23, 2011, sets out the pharmacy fee guideline.
3. Neither party to this dispute submitted any explanation of benefits or reason to support the denial of payment.

Issues

Is the requestor entitled to reimbursement for pharmacy services rendered on August 1, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $93.91 for pharmacy

services related to prescription drug 49483-0618-50 rendered on August 1, 2019.

2. The Austin carrier representative for Old Republic Insurance Co is White Espey PLLC. White Espey PLLC acknowledged receipt of the copy of this medical fee dispute on December 11, 2019. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).
3. Because neither party to this dispute submitted any explanation of benefits or reason to support the denial of payment, the disputed services will be reviewed per the fee guideline.
4. The fee guidelines for disputed services are found in 28 TAC §134.503.
5. 28 TAC §134.503(b) states, "For coding, billing, reporting, and reimbursement of prescription drugs and nonprescription drugs or over-the-counter medications, Texas workers' compensation system participants shall apply the provisions of Chapters 133 and 134 of this title (relating to General Medical Provisions and Benefits--Guidelines for Medical Services, Charges, and Payments, respectively)."
6. 28 TAC §134.503(c)(1)(A) states, "The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of: (1) 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: (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount."

   Using the above formula the DWC finds:

Generic NDC	AWP per Unit	Number of Units	DWC Conversion Factor (AWP X No. of Units X 125%)	Dispensing Fee	MAR or §134.503 (c) Lesser of MAR billed amount
49483-0618-50	$1.21350	30	$45.50	$4.00	$49.50
			Total Allowable		$49.50

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $49.50.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $49.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		1/16/2020
Signature	Medical Fee Dispute Resolution Officer	Date

RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 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 with the DWC. **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.