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Division of Workers' Compensation

PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Memorial Compounding RX

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-21-2184-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
July 28, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 23, 2021	Oral Medication	$118.21	$79.89
April 23, 2021	Oral Medication	$233.31	$223.76
April 23, 2021	Oral Medication	$202.85	$185.68
	Total	$554.37	$489.33

Requestor's Position

The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027.

Amount in Dispute: $554.37

Respondent's Position

The Austin carrier representative for Old Republic Insurance Co is White Espey. The representative was notified of this medical fee dispute on August 4, 2021.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available

information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.503 sets out the fee guidelines for oral medication.

Denial Reasons

Neither party submitted an explanation of benefits that support adjudication of the services in dispute.

Issues

1. What rule(s) apply to disputed services?

Findings

1. The requestor is seeking reimbursement for oral medication dispensed April 23, 2021. The insurance carrier provided insufficient evidence to support adjudication of the date of service in dispute. These medications will be reviewed per applicable fee guideline.

   28 Texas Administrative Code §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) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Hydrocodone	53746011005	G	0.67	90	$79.89	$118.21	$79.89
Tizanidine	55111018010	G	1.465	120	$223.76	$233.31	$223.76
Meloxicam	68382005105	G		30	$185.68	$202.85	$185.68

The total reimbursement is $489.33. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement of $489.33 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Old Republic Insurance Co must remit to Memorial Compounding RX $489.33 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.}

Authorized Signature

		October 7, 2021
Signature	Medical Fee Dispute Resolution Officer	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 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.