TDI 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
National Union Fire Ins Co of Pittsb PA

MFDR Tracking Number
M4-23-0331-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
October 10, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 12, 2022	68382-0805-01	$89.72	$44.27
	Total	$89.72	$44.27

Requestor's Position

"Before dispensing also this medication was preauthorized. The preauthorization # is – 4715764. Please pay this bill."

Amount in Dispute: $89.72

Respondent's Position

"Due to a system error, the Carrier's bill vendor did not receive this bill timely. It has been placed in line for payment and will be paid per fee guideline, plus interest.

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).

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 pharmacy services.

Denial Reasons

- HE – 70 Product/Service not covered

Issues

1. Is the insurance carrier's denial supported?

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

Findings

1. The requestor is seeking reimbursement for oral medication dispensed in August, 2022 The insurance company denied the disputed service stating the medication was not covered. Insufficient evidence was found to support the insurance carrier's denial.

   The respondent states the claim was to be re-processed and paid. Insufficient evidence was found to support the claim was adjudicated and paid. The disputed service will be reviewed per applicable fee guideline.

2. DWC Rule 28 Texas Administrative Code §134.503 (c)(1)(A)(B) states in pertinent part (c) 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;

   (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $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
Trazodone	6838280501	G	1.07	30	$44.27	$89.72	$44.27

The total reimbursement is $44.27. 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 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 respondent must remit to requestor $44.27 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		February 1, 2023
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.