TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-18-3916-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 12, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It looks like the carrier processed the claim but never issued a payment to our facility."

Amount in Dispute: $202.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After further review of the above referenced medical fee dispute, the Carrier maintains its position that payment is not due for the date of service in question."

Response Submitted by: New Hampshire Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 23, 2017	Meloxicam 15 mg Tablets	$202.85	$185.69

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 §133.240 sets out the procedures for payment or denial of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
4. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
5. The submitted explanation of benefits does not include a denial reason.

Issues

Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for this dispute?

Findings

Memorial is seeking reimbursement for Meloxicam 15 mg tablets dispensed on June 23, 2017. Per Explanation of Bill Review dated August 15, 2017, New Hampshire Insurance Company denied payment but failed to provide a reason for the denial.[1]

Because the insurance carrier failed to support its denial of reimbursement, Memorial is entitled to reimbursement. The reimbursement is calculated as follows[2]:

- Meloxicam 15 mg tablets: (4.845 x 30 x 1.25) + $4.00 = $185.69

The total allowable reimbursement amount is $185.69. 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 $185.69.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $185.69, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	October 30, 2018
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 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 the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division 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 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.

[1] 28 Texas Administrative Code §133.240(f)

[2] 28 Texas Administrative Code §134.503(c)