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 Pharmacy

Respondent Name
Technology Insurance Company Inc

MFDR Tracking Number
M4-22-1194-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
February 18, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 18,2021	68382-0051-05	$202.85	$0.00
		$202.85	$0.00

Requestor's Position

Memorial Compounding Pharmacy does not have a contract with Alternate Vendor therefore claim should be processed by the direct carrier.

Amount in Dispute: $202.85

Respondent's Position

The Carrier has submitted the bill in dispute for review, and an additional payment was made pursuant to the attached EOB.

Response submitted by: Downs Stanford PC

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 §134.530 sets out the requirements of prior authorization.

Denial Reasons

- W3 – No additional reimbursement allowed after review of appeal/reconsideration
- D3(P12) – The charge for the prescription drug is greater than the maximum reimbursement for a generic drug
- HEMD – These are non-covered services because this is not deemed a 'medical necessity' by the payer.

Issues

1. Is the insurance carrier's response supported?

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

Findings

1. The requestor is seeking reimbursement for the oral medication Meloxicam dispensed in November 2021. The insurance carrier indicates the dispute should be withdrawn as payment was made. Review of the submitted explanation of benefits dated February 12, 2022 shows an amount paid $185.69 however, this amount was also adjusted as a negative making the total net payment zero. The insurance carriers' response is not supported. The disputed service will be reviewed per applicable fee guidelines.
2. DWC Rule 28 Texas Administrative Code §134.530 (b) (1) (A) states preauthorization is only required for drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates,

   Review of the applicable Appendix A found:

Drug Class	Generic Name	Brand Name	Gener Equiv	Status
NSAIDs	Meloxicam	Mobic ®	Yes	Y
NSAIDs	Meloxicam	Vivlodex ®	No	N

   Insufficient evidence was found to support that the dispensed medication was the brand

name that did not require prior authorization. No reimbursement 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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is [not] entitled to additional reimbursement for the disputed services.

Authorized Signature

		April 27, 2022
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.