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
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-22-1222-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
FEBRUARY 22, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 15, 2021	Prescribed Medication	$202.85	$0.00
	Total	$202.85	$0.00

Requestor's Position

"The carrier denied the reconsideration based on lack of preauthorization. These medications do not require preauthorization therefore do not need a retrospective review."

Amount in Dispute: $202.85

Respondent's Position

The Austin carrier representative for New Hampshire Insurance Company is Flahive Ogden & Latson. Flahive Ogden & Latson was notified of this medical fee dispute on March 1, 2022. 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).

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).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.503 sets out the fee guidelines for pharmaceutical services.
3. 28 TAC §134.600 sets out the preauthorization guidelines.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- HE75 – Prior authorization required to process this bill.

Issues

1. Is the insurance carrier's denial reason supported?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for prescribed medication dispensed on November 15, 2021. The insurance carrier denied the disputed service due to lack of preauthorization, (denial description provided above.)

   28 TAC 134.600 (p)(11) states, "(p) Non-emergency health care requiring preauthorization includes… (11) drugs not included in the applicable division formulary…"

   The formulary consists of all available Food and Drug Administration (FDA) approved prescription and nonprescription drugs prescribed and dispensed for outpatient use, with the following exclusions:

   - drugs identified with a status of "N" in the current edition of the Official Disability Guidelines Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates

   Review of the Appendix A for November 2021 finds that Meloxicam has a N status and a Y status depending on the brand name, i.e., Mobix (Y Status) or Vivlodex (N Status).

   DWC Rule 28 TAC 134.530 (b)(1)(A) states in pertinent part preauthorization is required for drugs identified with status "N" in Appendix A, ODG Workers' Compensation Drug Formulary.

2. The submitted documentation was insufficient to support the dispensed medication did not require prior authorization. No payment is recommended.

Conclusion

The outcome of each independent medical fee dispute relies on the relevant evidence the requester and respondent present at the time of adjudication. Although all the evidence in this dispute may not have been discussed, it was considered.

The DWC finds the requester has not established that reimbursement is due. As a result, $0.00 is recommended.

Order

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

Authorized Signature

		May 13, 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 512-804-4812.