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 CO

MFDR Tracking Number
M4-22-1259-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
February 24, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 09, 2021	Cyclobenzaprine 5 MG tablet	$106.72	$184.56
	Omeprazole Dr 20 MG Capsule	$259.90	

Requestor's Position

"The above claimant received medication and the carrier still has not acknowledged receipt of service. The original bill was submitted to carrier on 01/21/2022. The Texas Labor Code Section 408.027 (b) requires that the carrier must pay, reduce, deny or determine to audit the health provider's claim no later than the 45th day after the date of receipt by carrier. Memorial did not receive any correspondence as per Rule 133.250 (a) we submitted a Request for Reconsideration. The reconsideration was submitted and received by the carrier on 02/08/2022 and then denied by the carrier. I have attached proof of submission for the first correspondences."

Amount in Dispute: $366.62

Respondent's Position

The Austin carrier representative for New Hampshire Insurance Co is FLAHIVE OGDEN & LATSON. FLAHIVE OGDEN & LATSON was notified of this medical fee dispute on March 16, 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).

Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §133.20 sets out medical bill submission by health care provider.

3. 28 TAC §134.503 sets out the pharmacy fee guidelines.

Denial Reasons

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

- 85 – Claim not processed
- 88 - DUR
- 65 – Patient is not covered
- 77 – Discounted NDC number

Issues

1. Did the requestor submit medical bills to the insurance carrier prior to medical fee dispute resolution?

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

Findings

1. The requestor is seeking reimbursement for oral medications dispensed on December 9, 2021.

   DWC Rule 28 TAC §134.503 (c) states 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:

NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
52817033050	G	$1.64	30	$61.52	$106.72	$61.52
62175011843	G	$1.64	60	$123.04	$259.90	$123.04
					Total	$184.56

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 $184.56 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 NEW HAMPSHIRE INSURANCE CO must remit to MEMORIAL COMPOUNDING RX $184.56 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

[redacted]

Signature

[redacted]

Medical Fee Dispute Resolution Officer

June 7, 2022

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.