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
M4-22-2345-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
July 1, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 11, 2022	Meloxicam	$202.85	$181.68

Requestor's Position

The above claimant received medication as prescribed by referral provider. Bill for date of service 04/11/2022 was processed and paid incorrectly. It looks like the carrier processed and paid only half of the total bill.

Amount in Dispute: $202.85

Respondent's Position

The carrier believes it has properly audited the bill. See attached EOBs.

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

2. 28 TAC §134.503 sets out the pharmacy fee guideline.

Denial Reasons

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

- 90563 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly
- 197 – Payment denied/reduced for absensce of precertification/authorization
- 5283 – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, providers contract or car

Issues

1. Is MEMORIAL COMPOUNDING RX entitled to additional reimbursement?

Findings

1. MEMORIAL COMPOUNDING RX is requesing reimbursement for Meloxicam dispensed on April 11, 2022.

   DWC Rule 28 Texas Administrative Code §134.503(c)(1)(A)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:

   (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $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
Meloxicam	68382005105	G	$4.84	30	$181.68	$202.85	$181.68
						Total	$181.68

The total reimbursement is $181.68. 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 of $181.68 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 $181.68 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

July 28, 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.