

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

MEMORIAL
COMPOUNDING RX

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-22-2508-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

July 28, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 4, 2022	Hydrocodone-Acetaminophen	\$163.31	\$133.26

Requestor's Position

The carrier denied the reconsideration based on claim not processed.

Amount in Dispute: \$163.313

Respondent's Position

Carrier did not respond to the DWC-60 request.

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:

- 85 – Claim not processed

Issues

1. Did the carrier respond to the DWC-60 request?
2. Is MEMORIAL COMPOUNDING RX entitled to additional reimbursement?

Findings

1. The Austin carrier representative New Hampshire Insurance Co is Flahive Ogden & Latson. Flahive Ogden Latson was notified of this medical fee dispute on August 02, 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).
2. MEMORIAL COMPOUNDING RX is requesting reimbursement for Hydrocodone-Acetaminophen dispensed on May 4, 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: $((\text{AWP per unit}) \times (\text{number of units}) \times 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
Hydrocodone/Acet	65162011550	G	\$2.65	40	\$132.26	\$163.31	\$132.26
						Total	\$132.26

The total reimbursement is \$132.26. 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 \$132.26 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 \$132.26 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature



Signature



Medical Fee Dispute Resolution
Officer

October 20, 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 electrónico CompConnection@tdi.texas.gov.

