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
Starr Indemnity & Liability Co

MFDR Tracking Number
M4-23-0104-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 12, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 7, 2022	65862-0805-30	$493.32	$0.00
	Total	$493.32	$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: $493.32

Respondent's Position

The Austin carrier representative for Starr Indemnity & Liability Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on September 20, 2022.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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 for prior authorization of pharmacy services.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 9D (P12) – The charge for the closed formulary drug requires prior authorization as defined within Texas Administrative Code Chapter 134. Section 134.530 and 134.540. If prior authorization was obtained, please resubmit with a copy of the required information
- N3 (B20) – A reduction was made because a different provider has billed for the exact services on a previous bill
- ZR (P12) – The provider or a different provider has billed for the exact service on a previous bill where no allowance was originally recommended

Issues

1. Did the respondent support their position statement?

Findings

1. The requestor is seeking reimbursement of oral medication dispensed on June 7, 2022. The insurance carrier denied the claim as a duplicate and for lack of prior authorization.

   Review of the submitted pharmacy claim found the disputed medication is Armodafinil Tab 50mg.

   DWC Rule 134.530 (b)(1)(A) states in pertinent part 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 the medication, Armodafinil is listed as a "N" drug. Insufficient evidence was found to support prior authorization was obtained.

   No payment 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

Signature	Medical Fee Dispute Resolution Officer	January 6, 2023 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.