



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Memorial Wellness Pharmacy

Respondent Name

Allmerica Financial Benefit Insurance Co

MFDR Tracking Number

M4-24-0129-01

Carrier's Austin Representative

Box Number 47

DWC Date Received

September 14, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 10, 2023	31722-0168-60 Duloxetine Cap 20mg	\$267.20	\$266.13
		\$267.20	\$266.13

Requestor's Position

"I have attached the EOBs as well as the documentation to prove that Memorial Wellness Pharmacy has met the requirements to receive reimbursement."

Amount in Dispute: \$267.20

Respondent's Position

"Memorial Wellness Pharmacy filled a prescription for Duloxetine on 2/10/23 in the amount of \$267.20. The carrier denied the medication as no supporting medical documentation was provided by the prescriber regarding the rationale prescribing this medication after the claimant was placed at maximum medical improvement on 11/22/22 for compensable (redacted).

Response submitted by: Hanover Insurance Group

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 of prior authorization.
3. [28 TAC §134.503](#) sets out the fee guidelines for pharmacy services.

Denial Reasons

- D3(P12) – The charge for the prescription drug is greater than the maximum reimbursement for a generic drug.
- HEAL – Precertification/authorization/notification absent.

Issues

1. Does the disputed claim require prior authorization?
2. What rule(s) apply to disputed services?

Findings

1. The requestor is seeking reimbursement for oral medication dispensed on February 10, 2023. The insurance company denied Duloxetine Cap 20mg in the amount of \$267.20 for lack of prior authorization.

DWC Rule §134.530 (b)(1) states in pertinent parts, "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.*" Review of applicable Appendix A of the ODG Treatment Guidelines found.

- Duloxetine has a "Y" status and does not require prior authorization.

DWC Rule §134.530 (g)(1)(2) states, Except as provided in subsection (f)(1) of this section, drugs that do not require preauthorization are subject to retrospective review for medical necessity in accordance with §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) and §133.240 of this title (relating to Medical Payments and Denials), and applicable provisions of Chapter 19 of this title.

(1) Health care, including a prescription for a drug, provided in accordance with §137.100 of this title is presumed reasonable as specified in Labor Code §413.017, and is also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a).

(2) In order for an insurance carrier to deny payment subject to a retrospective review for pharmaceutical services that are recommended by the division's adopted treatment

guidelines, §137.100 of this title, the denial must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established under Labor Code §413.017.

The documentation included with the respondent's position included a designated doctor examination dated February 1, 2023. This document did not include any indication as to the reasonableness of the disputed medication or meets the requirements of utilization review.

The service in dispute will be reviewed per applicable fee guideline.

2. DWC Rule 28 Texas Administrative Code §134.503 (c)(1)(A)(B) states in pertinent part (c) 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;

(B) Brand name drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.09) + \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
Duloxetine	31722016860	G	\$6.99	30	\$266.13	\$267.20	\$266.13

The total reimbursement is \$266.13. 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 reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that Allmerica Financial Benefit Insurance Co must remit to Memorial Wellness Pharmacy \$266.13 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

November 13, 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 electrónico CompConnection@tdi.texas.gov.