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 Wellness Pharmacy

Respondent Name
AIU Insurance Company

MFDR Tracking Number
M4-24-0130-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 14, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 14, 2023	Prescribed Medication	$106.72	$65.52
	Total	$106.72	$65.52

Requestor's Position

"Memorial Wellness Pharmacy has received several denials for the bill with date of service 06/14/2023. The carrier denied the original bill as well as the reconsideration based on (LACK OF PREAUTHORIZATION). Memorial did not receive any additional denial codes for the rejection of this bill from the carrier."

Amount in Dispute: $106.72

Respondent's Position

"The entitlement to reimbursement for the subject medical bill has been denied on an extent of injury basis (medication is for treatment unrelated to the compensable injury). Under 28 TAC 133J07(f)(3)(C), this request must be DISMISSED."

Response Submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.530 sets out the fee guidelines for pharmaceutical services.

Denial Reasons

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

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

Issues

1. Is the insurance carrier's denial reason supported?
2. What rules apply to disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor is seeking reimbursement for Cyclobenzaprine HCI 10 mg dispensed on June 14, 2023. The insurance carrier denied the medication due to lack of authorization.

   28 TAC §134.530 (b) states in pertinent part that preauthorization is only required for drugs identified with a status on "N" in the current edition of the ODG Treatment Comp (ODG) / Appendix A.

   Review of Appendix A for the date of service in dispute found the medication, Cyclobenzaprine is listed as a "Y" drug. Preauthorization was not required.

   The insurance carrier's denial is not supported, the service in dispute will be reviewed per the applicable fee guideline.

2. The requestor is seeking reimbursement for prescribed medication dispensed on June 14, 2023. The service in dispute will be reviewed per applicable fee guideline. 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 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:

• 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	AWP Formula	Billed Amount	Lesser of AWP and Billed Amount
Cyclobenzaprine HCl 10 mg	16571078310	G	1.64050/#30	$65.52	$106.72	$65.52

3. The DWC finds that the requestor is entitled to reimbursement in the amount of $65.52. Therefore, this amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies on the relevant evidence the requester and respondent present at the time of adjudication. Although all the evidence in this dispute may not have been discussed, it was considered.

The DWC finds the requester has established that reimbursement is due. As a result, the amount ordered is $65.52.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requester the amount of $65.52 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		December 15, 2023
Signature	Medical Fee Dispute Resolution Officer	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 512-804-4812.