



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Memorial Wellness Pharmacy

**Respondent Name**

New Hampshire Insurance Co

**MFDR Tracking Number**

M4-24-0670-01

**Carrier's Austin Representative**

Box Number19

**DWC Date Received**

November 17, 2023

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 21, 2023	49483-0699-01 Acetaminophen Tab 650 mg	\$67.21	\$9.74
August 21, 2023	71093-0120-05 Gabapentin Cap 100 mg	\$73.40	\$23.88
August 21, 2023	59651-0361-05 Ibuprofen 600 mg	\$89.14	\$43.56
		\$229.75	\$77.18

### Requestor's Position

"The carrier denied the bill based on **LACK OF PREAUTHORIZATION**. These medications do not require preauthorization therefore do not need a retrospective review."

**Amount in Dispute:** \$229.75

## Respondent's Position

"This letter acknowledges receipt of your Network (HCN) complaint on November 21, 2023. Complaints must be made no later than 90 days after the date of the issue arises that is the basis of the complaint."

**Response submitted by:** Helmsman Management Services LLC

## 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

- 5917 – Pre-authorization was required, but not requested for this service per DWC Rule 134.600.

### Issues

1. What rule(s) apply to disputed services?

### Findings

1. The requestor is seeking reimbursement for oral medication dispensed on August 21, 2023. The insurance carrier denied the disputed service based on lack of prior authorization. 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. Review of the applicable Appendix A found insufficient evidence to support the disputed oral medication require prior authorization. The insurance carrier's denial is not supported.

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

DWC Rule 28 TAC §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: ((AWP per unit) x (number of units) x 1.25) + \$4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs: ((AWP per unit) x (number of units) x 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
Acetaminophen	49483069901	G	0.102	45	\$9.74	\$67.21	\$9.74
Gabapentin	71093012005	G	0.53	30	\$23.88	\$73.40	\$23.88
Ibuprofen	59651036105	G	0.527	60	\$43.56	\$89.14	\$43.56
						\$229.75	\$77.18

The total reimbursement is \$77.18, 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 New Hampshire Insurance Co must remit to Memorial Wellness Pharmacy \$77.18 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

\_\_\_\_\_  
March 18, 2024  
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](http://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, call CompConnection at

1-800-252-7031, option 3 or email [CompConnection@tdi.texas.gov](mailto: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](mailto:CompConnection@tdi.texas.gov).