

## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

TRUSTRX PHARMACY

**Respondent Name**

NEW HAMPSHIRE INSURANCE CO

**MFDR Tracking Number**

M4-24-1725-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

April 10, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 10, 2023	Tramadol Hydrochloride 50 MG NDC 57664037708	\$129.62	\$35.41
June 8, 2023	Tramadol Hydrochloride 50 MG NDC 57664037713	\$95.86	\$34.62
<b>Total</b>		\$225.48	\$70.03

### Requestor's Position

"Please review the attach bill and process for the correct payment amount. I have attached a copy of the bill for date of service 01/10/23 along with a copy of the explanation of benefits and prescription.

\*\*\*Per the Texas ODG (Official Disability Guidelines) the medicaton TRAMADOL does require prior authorization or pre-certificaiton. I have ATTACHED a copy of the Prior Authorization.\*\*\*"

**Amount in Dispute:** \$225.48

### Respondent's Position

The Austin carrier representative for New Hampshire Insurance Co is Flahive Ogden & Latson.

Flahive Ogden & Latson was notified of this medical fee dispute on April 16, 2024. 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).

## **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 (TAC) [§133.307](#) sets out the procedures for resolving medical fee disputes.
2. 28 TAC [§133.305](#) sets out the general medical provisions for disputes of medical bills.
3. 28 TAC [§133.240](#) sets out the procedures for medical payments and denial by the insurance carrier.
4. 28 TAC [§134.503](#) sets out the pharmacy fee guideline.
5. 28 TAC [§134.530](#) sets out the requirements of prior authorization for pharmacy services.
6. 28 TAC [§19.2009](#) sets out the requirements for notice of determinations made in utilization review.
7. 28 TAC [§19.2010](#) sets out the requirements prior to issuing an adverse determination.

### Denial Reasons

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

- 197 – Precertification/authorization/notification/pre-treatment absent
- 00663 – Reimbursement has been calculated according to state fee guidelines
- 4121 – Preauthorization required for drugs identified with a status of 'N' in the current edition of the 'Official Disability Guidelines' treatment in workers comp (ODG)/Appendix A "ODG Workers' Compensation Drug Formulary" and any updates
- 90438 – Payment denied/reduced for absence of precertification/authorization
- 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer

### Issues

1. Is insurance carrier denial of preauthorization supported for Tramadol?
2. Did the insurance carrier support utilization review?
3. Is the requestor entitled to reimbursement ?

Findings

1. The requestor is seeking reimbursement for Tramadol dispensed on January 10, 2023 and June 8, 2023. Insurance carrier denied the medication Tramadol based on no preauthorization/no precertification.

28TAC §134.530 (b)(1) states in pertinent part preauthorization is only required for drugs identified with a status of "N" in the current edition of Appendix A Workers Compensation Drug Formulary .

Review of the ODG / Appendix A finds Tramadol has a 'N' status.

<b>Drug Class</b>	<b>Generic Name</b>	<b>Brand Name</b>	<b>Gener Equiv</b>	<b>Status</b>
<b>Opioids</b>	<b>Tramadol Hydrochloride</b>	<b>Ultram</b>	<b>Yes</b>	<b>N</b>

Review of the submitted documentation provided by the requestor finds preauthorization approval for dates of service January 10, 2023 and June 8, 2023 for Tramadol.

Therefore, insurance carrier denial is not supported.

2. NEW HAMPSHIRE INSURANCE CO denied the disputed drugs with claim adjustment reason code "50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer."

28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding...medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding...medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021."

28 Texas Administrative Code §133.240(q) states that the insurance carrier is required to comply with 28 Texas Administrative Codes §§19.2009 and 19.2010 when denying payment based on an adverse determination.

Review of the submitted documentation finds the requestor submitted sufficient documentation to support that a utilization review was done in accordance with 28 Texas Administrative Codes §§19.2009.

Therefore, insurance carrier denial is not supported.

3. TrustRX Pharmacy is requesting reimbursement for Tramadol dispensed on January 10, 2023

and June 8, 2023.

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
Tramadol Hydrochloride	57664037708	G	\$0.08	30	\$35.41	\$129.62	\$35.41
Tramadol Hydrochloride	57664037713	G	\$0.82	30	\$34.62	\$95.89	\$34.62
						<b>Total</b>	<b>\$70.03</b>

The total reimbursement is \$70.03. This amount is recommended.

### Conclusion

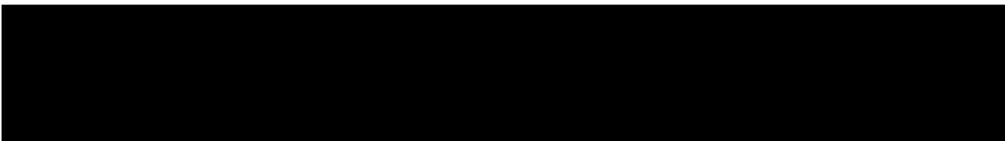
The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement of \$70.03 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 TrustRX Pharmacy \$70.03 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

June 14, 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, please 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).