



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

TrustRx Pharmacy

**Respondent Name**

Indemnity Insurance Co of North America

**MFDR Tracking Number**

M4-24-1982-01

**Carrier's Austin Representative**

Rep Box 15

**DWC Date Received**

May 10, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 18, 2023	NDC # 50228018010	\$103.90	\$103.90
June 15, 2023	NDC # 43386035801	\$75.72	\$75.72
July 10, 2023	NDC # 50228018010	\$103.90	\$103.90
July 13, 2023	NDC # 00406012505	\$77.36	\$77.36
August 17, 2023	NDC # 00406012505	\$77.36	\$77.36
October 18, 2023	NDC # 50228018010	\$103.90	\$103.90
October 18, 2023	NDC # 00406012505	\$77.36	\$77.36
October 26, 2023	NDC # 64980041109	\$320.02	\$320.02
<b>Total</b>		<b>\$939.52</b>	<b>\$939.52</b>

### Requestor's Position

"I have attached the Bills for DOS 05/18/23 for process of payment. Please see attached to this Resubmission is a copy of the 1st fax dated 08/17/23 for timely purposes. Which is 92 days. This would be before the timely filling of 95 days."

**Amount in Dispute:** \$939.52

## **Respondent's Position**

The Austin carrier representative for Indemnity Insurance Co of North America is Downs Stanford PC. Downs Stanford PC was notified of this medical fee dispute on May 14, 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 §133.305](#) sets out the general procedures for medical dispute resolution.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
3. [28 TAC §134.503](#) sets out the fee guidelines for pharmacy.

### **Denial Reasons**

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

- P2 – Not a work-related injury/illness and thus not the liability of the workers' compensation carrier.
- 18 – Exact duplicate claim/service.

### **Issues**

1. Is insurance carrier's denial reason(s) supported?
2. Is the requestor entitled to reimbursement?

### **Findings**

1. The requestor is seeking reimbursement in the amount of \$939.52 for medications dispensed on May 18, 2023, June 15, 2023, July 10, 2023, July 13, 2023, August 17, 2023, October 18, 2023, and October 26, 2023. The insurance carrier denied reimbursement with denial reason, "P2- Not a work-related injury/illness and thus not the liability of the workers' compensation carrier."

28 TAC 133.307 states, "(d) Responses. Responses to a request for MFDR must be legible and

submitted to the division and to the requestor in the form and manner prescribed by the division. (2) Response. On receipt of the request, the respondent must provide any missing information not provided by the requestor and known to the respondent. The respondent must also provide the following information and records: (H) If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier must attach any related Plain Language Notice in accordance with §124.2 of this title (concerning Insurance Carrier Reporting and Notification Requirements)."

A review of the medical records finds that the insurance carrier failed to submit documentation to support the denial reason "P2." The requestor is therefore entitled to reimbursement for the medications in dispute.

2. 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:  $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.25) + \$4.00$  dispensing fee per prescription = reimbursement amount;

DOS Year: 2023	Drug	NDC	Generic(G) Brand(B)	Price/Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed Amt
May 18	Gabapentin	50228018010	G	1.33	60	\$103.90	\$103.90	\$103.90
June 15	Hydrocodone Bitartrate/ Acetaminophen	43386035801	G	0.97	60	\$75.73	\$75.72	\$75.72
July 10	Gabapentin	50228018010	G	1.33	60	\$103.90	\$103.90	\$103.90
July 13	Hydrocodone Bitartrate/ Acetaminophen	00406012505	G	0.97	60	\$77.36	\$77.36	\$77.36
August 17	Hydrocodone Bitartrate/ Acetaminophen	00406012505	G	0.97	60	\$77.36	\$77.36	\$77.36
October 18	Gabapentin	50228018010	G	1.33	60	\$103.90	\$103.90	\$103.90
October 18	Hydrocodone Bitartrate/ Acetaminophen	00406012505	G	0.97	60	\$77.36	\$77.36	\$77.36
October 26	Pregabalin	64980041109	G	8.42	30	\$320.02	\$320.02	\$320.02
<b>Total</b>						\$939.53	\$939.52	\$939.52

The total reimbursement is \$939.52. 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 requestor has established that reimbursement of \$939.52 is due.

## **Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$939.52 reimbursement for the disputed medications. It is ordered that respondent must remit to the requestor \$939.52 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

## **Authorized Signature**

_____	_____	July 9, 2024
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](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).