



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

TrustRx Pharmacy

**Respondent Name**

New Hampshire Insurance Co

**MFDR Tracking Number**

M4-24-2095-01

**Carrier's Austin Representative**

Rep Box 19

**DWC Date Received**

May 30, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 1, 2023	NDC # 16714017101	\$95.64	\$95.64
June 29, 2023	NDC # 16714017101	\$95.64	\$95.64
<b>Total</b>		\$191.28	\$191.28

### Requestor's Position

"DOS 06/01/23- Medication TIZANIDINE is a 'Y' status on the Texas ODG. This does not require Prior Auth... This was the original script for DOS 06/01/23 which was refilled on DOS 07/31/23 and this was paid"

**Amount in Dispute:** \$ 191.28

### Respondent's Supplemental Position

"First Script - After researching, our findings indicate Denial under CN: 49560510 is correct for Date of Service 6/1/23 for medications: TIZANIDINE HCL 2 MG TABLET."

**Response Submitted by:** Gallagher Bassett Services

# 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:

- 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.
- 000050 – 01-Services not authorized as required.
- 5721 – To avoid duplicate bill denial, for all reconsiderations/adjustments/additional payment requests, submit a copy of this EOR or clear notation that a recon is...
- 90563, 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 90950 – This bill is a reconsideration of a previously reviewed bill; allowance amounts reflect any changes to the previous payment.
- 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, providers contract.

## **Issues**

1. Is insurance carrier's denial for medical necessity supported?
2. Is the insurance carrier's denial due to pre-authorization supported?
3. Is the requestor entitled to reimbursement?

## **Findings**

1. The requestor is seeking reimbursement in the amount of \$191.28 for medication(s) dispensed on June 1, 2023, and June 29, 2023.

The insurance carrier denied reimbursement due to "not deemed a 'medical necessity' by the payer." The insurance carrier notified the requestor of the denial on an explanation of benefits as defined by 28 TAC §133.240.

A review of the submitted documentation finds that the insurance carrier did not include supporting documentation to DWC, as required by 28 TAC §133.307 (d)(2)(I). Specifically, the insurance carrier did not support that it conducted a utilization review and presented an adverse determination to the requestor as required by 28 TAC §19.2005.

The DWC concludes that the medical necessity issue is not supported. As a result, the disputed services are eligible for review.

2. The insurance carrier denied the disputed medication due to lack of pre-authorization. 28 TAC §134.530 "(b) Preauthorization for claims subject to the Division's closed formulary.

(1) Preauthorization is only required for:

(A) drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates..."

The DWC finds that the medications in dispute are identified with a status "Y" in the current edition of the ODG Treatment guidelines. The insurance carrier's denial due to lack of pre-authorization is not supported. As a result, the requestor is entitled to reimbursement.

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

Drug	NDC	Generic(G)/ Brand(B)	Price/ Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed Amt
Tizanidine	16714017101	G	1.22	60	\$95.64	\$95.64	\$95.64
Tizanidine	16714017101	G	1.22	60	\$95.64	\$95.64	\$95.64
TOTAL					\$191.28	\$191.28	\$191.28

The total reimbursement is \$191.28. 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 \$191.28 is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$191.28 reimbursement. It is ordered that respondent must remit to the requestor \$191.28 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).