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
EZ Scripts LLC

Respondent Name
Highlands Insurance Co

MFDR Tracking Number
M4-24-2480-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
July 10, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 20, 2023	10702-0187-50	$536.65	$536.65
August 17, 2023	00406-0523-01	$536.65	$536.65
September 14, 2023	10702-0187-50	$536.65	$536.65
October 12, 2023	00406-0523-01	$536.65	$536.65
November 9, 2023	00406-0523-05	$536.65	$536.65
December 7, 2023	00406-0523-01	$536.65	$536.65
		$3,219.90	$3,219.90

Requestor's Position

"Oxycodone APAP 10-325 MG was a Y drug on the ODG formulary each time it was filled and did not require preauthorization."

Amount in Dispute: $3,219.90

Respondent's Position

The Austin carrier representative for Highlands Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on July 16, 2024.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within

14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available

Response submitted by: n/a

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

- 197 – Precertification/authorization/notification/pre-treatment absent.
- PP – Paid in Full – No adjustment to charged amount.
- 75 – Prior authorization required.
- 85 – Claim not processed.

Issues

1. Is the insurance carrier's denial supported?
2. What rule(s) apply to disputed services?

Findings

1. The requestor is seeking reimbursement for the medication Oxycodone APAP dispensed from July 20, 2023, through December 7, 2023. The insurance carrier denied the medication due to lack of prior authorization.

   DWC Rule 28 TAC §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 this medication is not listed as a "N" drug. The insurance carrier's denial is not supported. The services in dispute will be reviewed per

applicable fee guidelines.

2. 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
Oxycodone/ Acetaminophen	00406052301 00406052305 10702018750	G	3.55	120	$536.82	$536.65	$536.65

The reimbursement amount for each disputed date of service is $536.65 for a total recommended amount of $3,219.90. 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 Highlands Insurance Co must remit to EZ Scripts LLC $3,219.90 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	October 22, 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. 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 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.