



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

EZ Scripts LLC

Respondent Name

Old Republic Insurance Co

MFDR Tracking Number

M4-25-0074-01

Carrier's Austin Representative

Rep Box 44

DWC Date Received

September 10, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 22, 2024	NDC # 57237-0009-30 Mirtazapine	\$107.76	\$107.75
March 22, 2024	NDC # 70954-0021-10 Prazosin HCL	\$85.86	\$85.86
April 2, 2024	NDC # 13668-0218-90 Aripiprazole	\$1,208.16	\$0.00
April 18, 2024	NDC # 70954-0021-10 Prazosin HCL	\$85.86	\$85.86
April 30, 2024	NDC # 13668-0218-90 Aripiprazole	\$1,208.16	\$0.00
May 3, 2024	NDC # 70954-0020-10 Prazosin HCL	\$152.72	\$152.72
May 3, 2024	NDC # 57237-0009-30 Mirtazapine	\$107.76	\$107.75
May 29, 2024	NDC # 67877-0432-03 Aripiprazole	\$1,204.19	\$0.00
May 29, 2024	NDC # 70954-0020-10 Prazosin HCL	\$152.72	\$152.72
May 29, 2024	NDC # 57237-0009-30 Mirtazapine	\$107.76	\$107.75
June 28, 2024	NDC # 70954-0020-10 Prazosin HCL	\$152.72	\$152.72
June 28, 2024	NDC # 57237-0009-30 Mirtazapine	\$107.76	\$107.75
Total		\$4,681.43	\$1,060.88

Requestor's Position

"Mirtazapine filled on 03/22/2024, 05/03/2024, 05/29/2024, and 06/28/2024 was denied with the code 'Product/Service Not Covered.' Prazosin filled on 03/22/2024, 04/18/2024, 05/03/2024, 05/29/2024, and 06/28/2024 were denied with the code 'Product/Service Not Covered.' EZ Scripts submitted appeals which were denied as duplicates. The Aripiprazole filled on 04/02/2024, 04/03/2024, and 05/29/2024 was an 'N' drug on the ODG formulary. The medication was preauthorized and approved by Sedgwick utilization review on 04/02/2024, with review number 5512494, an approval period of 03/22/2024-06/22/2024, and with two refills. The medication was filled within the parameters of the determination. Sedgwick utilization review would not provide the corresponding determination letter."

Amount in Dispute: \$4,681.43

Respondent's Position

The Austin carrier representative for Old Republic Insurance Company is White Espey PLLC. White Espey PLLC was notified of this medical fee dispute on September 17, 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.
4. 28 Texas Administrative Codes §§134.530 and 134.540 sets out the closed formulary requirements, effective January 17, 2011, 35 TexReg 11344.

Denial Reasons

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

- HE70 – Product/Service not covered.
- 60(B13) – The provider has billed for the exact services on a previous bill.
- N3(B20) – A reduction was made because a different provider has billed for the exact services on a previous bill.
- ZR(P12) – The provider or a different provider has billed for the exact service on a previous bill where no allowance was originally recommended.
- 9D(P12) - The charge for the Closed Formulary Drug requires Prior Authorization as defined within Texas Administrative Code Chapter 134, Section 134.530 and 134.540. If Prior Authorization was obtained, please resubmit with a copy of the required information.

Issues

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

Findings

1. The requestor seeks payment in the amount of \$4,681.43, for prescriptions Aripiprazole, Mirtazapine and Prazosin dispensed between March 22, 2024, and June 28, 2024.

Submitted documentation indicates that the insurance carrier denied the disputed drugs based on preauthorization. Preauthorization is only required for:

- drugs identified with a status of "N" in the current edition of the ODG Appendix A
- any compound prescribed before July 1, 2018, that contains a drug identified with a status of "N" in the current edition of the ODG Appendix A
- any prescription drug created through compounding prescribed and dispensed on or after July 1, 2018; and
- any investigational or experimental drug.

The DWC finds that medications Mirtazapine and Prazosin in question are identified with a status of "Y" in the applicable edition of the ODG, Appendix A. Therefore, these drugs do not require preauthorization for this reason. The DWC concludes that the insurance carrier's denial of payment of the disputed drug based on preauthorization is not supported.

The DWC finds that Aripiprazole in question is identified with a status of "N" in the applicable edition of the ODG, Appendix A. Therefore, these drugs require preauthorization for this reason. The requestor provided information of pre-authorization request and utilization review number in their statement, however copies of the documentation of the review from the insurance carrier was not provided, only a review number. The DWC concludes that the insurance carrier's denial of payment of the disputed drug based on preauthorization is supported.

- The DWC concludes that the disputed prescription for Aripiprazole rendered on April 2, 2024, April 30, 2024, and May 29, 2024, is identified as an "N" status drug. As a result, pre-authorization was required, and documentation of authorization was not provided. Because the insurance carrier's denial reason was supported reimbursement is not recommended for this prescription.

The DWC concludes that the disputed prescriptions for Mirtazapine and Prazosin rendered on dates between March 22, 2024, and June 28, 2024, are identified as "Y" status drugs. Because the insurance carrier's denial reason was not supported, reimbursement is recommended for Mirtazapine and Prazosin HCL prescriptions.

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: $((\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 Amt
Mirtazapine	57237000930	G	2.76667	30	$\$107.75 \times 4$ = \$431.00	$\$107.76 \times 4$ = \$431.04	$\$107.75 \times 4$ = \$431.00
Prazosin HCL	70954002010	G	1.32240	90	$\$152.77 \times 3$ = \$458.31	$\$152.72 \times 3$ = \$458.16	$\$152.72 \times 3$ = \$458.16
Prazosin HCL	70954002110	G	2.18280	30	$\$85.86 \times 2$ = \$171.72	$\$85.86 \times 2$ = \$171.72	$\$85.86 \times 2$ = \$171.72
TOTAL					\$1,061.03	\$1,060.92	\$1,060.88

The total reimbursement for Mirtazapine and Prazosin HCL is \$1,060.88. 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 is due for disputed medications Mirtazapine and Prazosin HCL.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed prescriptions. It is ordered that the Respondent must remit to the Requestor \$1,060.88, 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

December 20, 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, 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 electrónico CompConnection@tdi.texas.gov.