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
TrustRx Pharmacy

Respondent Name
AIU Insurance Co

MFDR Tracking Number
M4-25-0518-01

Carrier's Austin Representative
Rep Box 19

DWC Date Received
October 31, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 6, 2024	Tramadol Hydrochloride	$45.65	$45.64

Requestor's Position

"I have attached the Bill for DOS 02/06/24 for processing of payment. I have attached a copy of the Bill, the prescriptions, and the ORIGINAL denial. Attached is a copy of the Prior Authorization for medication TRAMADOL."

Amount in Dispute: $45.65

Respondents' Position

The Austin carrier representative for AIU Insurance Co is Flahive, Ogden & Latson. Flahive, Ogden & Latson was notified of this medical fee dispute on November 5, 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 had billed for the exact services on a previous bill.
- 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.
- ZR (P12) – The provider or a different provider has billed for the exact service on a previous bill where no allowance was originally recommended.
- P12 9D, ZR – Workers' compensation jurisdictional fee schedule adjustment.
- B13 60 – Previously paid. Payment for this claim/service may have been provided in a previous payment.

Issues

1. Are the insurance carrier's denial reasons supported?
2. Did the requestor obtain preauthorization for the drug in dispute?
3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement in the amount of $45.65 for a prescription dispensed on February 6, 2024. The insurance carrier did not respond to the MFDR request.

   The insurance company denied the disputed service indicating that the medication was not covered. Insufficient evidence was found to support the insurance carrier's denial.

   The insurance company also denied the medication, indicating that the provider billed for the exact services on a previous bill and that a previous payment was issued. No evidence was found to support these denial reasons.

2. A review of the submitted documentation finds 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 the drugs in question are identified with a status of "N" in the applicable edition of the ODG, Appendix A. Therefore, these drug requires preauthorization for this reason.

   A review of the medical records finds, prior authorization was obtained by requester on January 31, 2024, from Sedgwick Claims Management Services on behalf of respondent AIU Insurance Company. Based on the documentation provided, DWC finds that the carrier failed to sufficiently support the denial for reimbursement. The requestor is therefore entitled to reimbursement for the medications in dispute.

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 per unit) x (number of units) x 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
Tramadol HCl	29300035510	G	0.83289	40	$45.64	$45.65	$45.64
				TOTAL	**$45.64**	**$45.65**	**$45.64**

The total reimbursement of $45.64 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 of $45.64 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 the respondent must remit to the requestor $45.64 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		February 13, 2025
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. 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 electronico CompConnection@tdi.texas.gov.