



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

TrustRx Pharmacy

**Respondent Name**

Safety National Casualty Corp

**MFDR Tracking Number**

M4-25-0917-01

**Carrier's Austin Representative**

Rep Box 19

**DWC Date Received**

December 26, 2024

### Summary of Findings

Dates of Service	Dispute Services	Amount in Dispute	Amount Due
April 5, 2024	NDC # 00074-7094-30 Qulipta	\$1,433.10	\$1,433.10

### Requestor's Position

"I have attached the bill for date of service 04/05/24 (\$1433.10) for processing payment, I have attached a copy of this bill, the prescriptions and the ORIGINAL Denial. Attached is a Prior Authorization for the medication Qulipta."

**Amount in Dispute:** \$1,433.10

### Respondents' Position

The Austin carrier representative for Safety National Casualty Corp is Flahive Ogden & Latson. Flahive Ogden & Latson was notified of this medical fee dispute on December 31, 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 TAC [§§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:

- 197 - Payment denied/reduced for absence of precertification/authorization.
- 4121 - Preauthorization is required for drugs identified with a status of "N" in the current edition of the official disability guidelines treatment in workers' comp "(ODG)/Appendix A, ODG workers' compensation drug formulary" and any updates.
- 247 - A payment or denial has already been
- 18 - Exact duplicate claim/service.

### **Issues**

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

### **Findings**

1. The requestor is seeking reimbursement in the amount of \$1,433.10 for medication dispensed on April 5, 2024. The insurance carrier is denying reimbursement for absence of pre-certification/authorization.

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 drug in question is identified with a status of "N" in the applicable edition of the ODG, Appendix A. Therefore, this drug required preauthorization for this reason.

A review of the medical records finds, prior authorization was obtained by the requester on March 8, 2024, from CorVel Healthcare Corporation on behalf of respondent CCMSI, Safety National Casualty Corp. 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 medication 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:

- Brand 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
Qulipta 60 mg	00074709430	B	43.70333	30	\$1,433.10	\$1,433.10	\$1,433.10

The total reimbursement is \$1,433.10. 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 of \$1,433.10 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 \$1,433.10 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

March 20, 2025  
\_\_\_\_\_  
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).