



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

TrustRx Pharmacy

**Respondent Name**

Hartford Casualty Insurance Co

**MFDR Tracking Number**

M4-24-1728-01

**Carrier's Austin Representative**

Rep Box 47

**DWC Date Received**

April 11, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 15, 2023	NDC # 65162063709	\$408.62	\$408.62
August 15, 2023	NDC # 29300012510	\$185.69	\$185.69
<b>Total</b>		<b>\$594.31</b>	<b>\$594.31</b>

### Requestor's Position

"I have attached the Bill for DOS 08/15/23 for processing of payment. Attached to the appeal is a copy of the Bill, Denial, Prescription and supporting documents to show payment was reversed and this is payable. The authorized Physician on this workman camp claim is DR. Anibal Rossel. The prescriptions attached to this appeal with show that is who prescribed the medication."

**Amount in Dispute:** \$ 594.31

### Respondent's Position

The Austin carrier representative for Hartford Casualty Insurance Co is Burns Anderson Jury Brenner. Burns Anderson Jury Brenner was notified of this medical fee dispute on April 16, 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.

## Denial Reasons

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

- HEPO - The prescribing/ordering provider is not eligible to prescribe/order the service billed.
- 60 (B13) – The provider has billed for the exact services on a previous bill.
- B13: 60 – Previously paid. Payment for the claim/service may have been provided in a previous payment.

## Issues

1. Did the insurance carrier issue payment for meloxicam rendered on August 15, 2023?
2. Is the insurance carrier's denial reason supported?
3. Is the requestor entitled to payment for the medications in dispute?

## Findings

1. The requestor is seeking payment in the amount of \$185.69 for Meloxicam dispensed on August 15, 2023. The insurance carrier denied payment for the drug in question stating, "Previously paid. Payment for the claim/service may have been provided in a previous payment." The respondent did not submit a response to the medical fee dispute to support this denial

A review of the explanation of benefits (EOB) dated September 7, 2023, finds that the insurance carrier indicated that a payment of \$185.69 was issued for Meloxicam rendered on August 15, 2023. Based on the documentation provided, DWC finds that the carrier failed to support that a payment was issued. The EOB did not contain identifiable information, such as a check number or routing number. The insurance carriers' denial is not supported, and the requestor is entitled to payment for Meloxicam.

2. The requestor seeks payment in the amount of \$408.62 for Pantoprazole Sodium dispensed on August 15, 2023. The insurance carrier denied payment due to prescribing/ordering provider is not eligible to prescribe/order the service billed. The requestor did not submit a response to medical fee dispute resolution to support the claim that the prescribing/ordering provider is not eligible to prescribe/order the service billed. As a result, the requestor is entitled to payment for Pantoprazole Sodium.
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:  $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \$4.00$  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
Pantoprazole Sodium	65162063709	G	10.79	30	\$408.63	\$408.62	\$408.62
Meloxicam	29300012510	G	4.845	30	\$185.69	\$185.69	\$185.69
TOTAL					\$594.32	\$594.31	\$594.31

The requestor seeks \$594.31; therefore, 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 payment in the amount of \$594.31 is due.

### **Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$594.31 reimbursement. It is ordered that respondent must remit to the requestor \$594.31 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

June 21, 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](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).