



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

TRUSTRX Pharmacy

Respondent Name

Mitsui Sumitomo Insurance Co of America

MFDR Tracking Number

M4-24-1984-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

May 13, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 14, 2023	Left blank	\$489.25	\$489.25
		\$489.25	\$489.25

Requestor's Position

"Attached to this Medical Fee Dispute Resolution request are the Copy of the original Bill(s) sent to the carrier Copy of original denials Copy of appeals that were sent into carrier (regarding original denial) Copy of denials after appeals were processed."

Amount in Dispute: \$489.25

Respondent's Position

The Austin carrier representative for Mitsui Sumitomo Insurance Co of America is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on May 21, 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:

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. [TLC 408.021](#) Sets out Entitlement To Medical Benefits.
3. [28 TAC §134.530](#) sets out the requirements of prior authorization.
4. [28 TAC §134.503](#) sets out the fee guidelines for pharmacy services.

Denial Reasons

- W11 – Entitlement to benefits (TX03).

Issues

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

Findings

1. The requestor did not list a description of treatment or service codes in dispute on their submitted DWC60. They show date of service in September 14, 2023 with an amount in dispute listed as \$489.25. Review of the submitted documentation found DWC066 (pharmacy claim form) for date of service September 14, 2023 for the medication Diclofenac Sodium 10mg/g and Duloxetine 20 mg/1. These are the services that will be reviewed during this medical fee dispute.
2. The insurance carrier denied the services based on entitlement to benefits.
TLC Sec. 408.021. Entitlement To Medical Benefits states,
(a) An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that:
 - (1) cures or relieves the effects naturally resulting from the compensable injury;
 - (2) promotes recovery; or
 - (3) enhances the ability of the employee to return to or retain employment.

(b) Medical benefits are payable from the date of the compensable injury.

(c) Except in an emergency, all health care must be approved or recommended by the employee's treating doctor.

(d) An insurance carrier's liability for medical benefits may not be limited or terminated by agreement or settlement.

The insurance carrier did not submit a position statement to support why their denial should be upheld. The service in dispute will be reviewed per applicable fee guideline.

3. DWC Rule 28 Texas Administrative Code §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: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 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
Diclofenac Sodium	21922000909	G	0.583	300	\$222.81	\$222.81	\$222.81
Duloxetine	68180029407	G	6.998	30	\$266.44	\$266.44	\$266.44
						\$489.25	\$489.25

The total reimbursement is \$489.25. 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 additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 reimbursement for the disputed services. It is ordered that Mitsui Sumitomo Insurance Co of America must remit to TRUSTRX Pharmacy \$489.25 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

July 30, 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 electrónico CompConnection@tdi.texas.gov.