



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

TrustRx Pharmacy

Respondent Name

Starr Indemnity & Liability Co

MFDR Tracking Number

M4-24-1994-01

Carrier's Austin Representative

Rep Box 19

DWC Date Received

May 14, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 13, 2023	NDC # 16714061101	\$ 217.62	\$ 217.62
Total		\$ 217.62	\$ 217.62

Requestor's Position

"Please review the attach bill and process for the correct payment amount. I have attached a copy of the bill for date of service 11/13/23 along with a copy of the explanation of benefits, prescription... I have also attached a copy of the letter of medical necessity to this appeal for re processing for correct payment. There is no current dispute on claim."

Amount in Dispute: \$ 217.62

Respondent's Position

The Austin carrier representative for Starr Indemnity & Liability Co is Flahive Ogden & Latson. Flahive Ogden & Latson was notified of this medical fee dispute on May 21, 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:

- B20: N3 – Procedure/service was partially or fully furnished by another provider.
- N3 (B20) – A reduction was made because a different provider has billed for the exact service on a previous bill.
- HE70 – Product/Service not covered.
- P12: ZR – Workers' compensation jurisdictional fee schedule adjustment.
- B13: 60 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 60 (B13) – The provider has billed for the exact services on a previous bill.
- ZR (P12) - The provider has billed for the exact services on a previous bill for the exact service on a previous bill where no allowance was originally recommended.

Issues

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

Findings

1. The requestor is seeking reimbursement in the amount of \$ 217.62 for medication dispensed on November 13, 2023. The insurance carrier is denying reimbursement due to the denial reasons indicated above. The insurance carrier did not respond to the MFDR request for review. Based on the documentation provided, DWC finds that the carrier failed to support the denials for reimbursement. The requestor is therefore entitled to reimbursement for the medications 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:

- 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
Sertraline HCl	16714061101	G	2.84	60	\$ 217.62	\$ 217.62	\$ 217.62
Total					\$ 217.62	\$ 217.62	\$ 217.62

The total reimbursement is \$ 217.62. 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 of \$ 217.62 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 respondent must remit to the requestor \$ 217.62 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	Date
		July 9, 2024

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.