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
Injured Workers Pharmacy, LLC

Respondent Name
Hanover Insurance Company

MFDR Tracking Number
M4-25-0595-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
November 8, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 9, 2023	59651036205	$55.38	$55.38
February 20, 2024	70512010610	$307.46	$307.46
March 15, 2024	59651036205	$55.38	$55.38
April 15, 2024	70512010610	$307.46	$307.46
	59651036205	$55.38	$55.38
May 15, 2024	70512010610	$307.46	$307.46
	59651036205	$55.38	$55.38
	Total	$1,143.90	$1,143.90

Requestor's Position

"The attached bills were denied by HANOVER INSURANCE under 'product/service not covered' we submitted appeals due to the inconsistency of the denials and received a 'lack of prior authorization' denial … We are not aware of any disputes and/or medical exams supporting non-payment."

Amount in Dispute: $1,143.90

Respondent's Position

"I have reached out to Hanover for a status on the response."

Response Submitted by: Burns Anderson Jury & Brenner

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.503 effective October 23, 2011, 36 TexReg 6949 sets out the fee guidelines for pharmaceutical services prior to November 28, 2024.

3. 28 Texas Administrative Codes §§134.530 and 134.540 effective January 17, 2011, 35 TexReg 11344 set out the closed formulary requirements for pharmaceutical services prior to November 28, 2024.

Denial Reasons

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

- HEA1 – Claim/Service denied.
- CMR – Payment Disallowed: Billing Error: Line-item service previously processed electronically and reimbursement/denial
- HE70 – Product/service not covered.
- HE75 – Prior Authorization required to process this bill.
- B20:N3 – Procedure/service was partially or fully furnished by another provider
- P12:ZR – Workers' compensation jurisdictional fee schedule adjustment.
- N3(B20) – A reduction was made because a different provider has billed for the exact services on a previous bill.
- ZR(P12) – The provider or a different provider has billed for the exact service on a previous bill where no allowance was originally recommended.

Issues

1. Is Hanover Insurance Company's denial based on coverage supported?

2. Is Hanover Insurance Company's denial based on compensability supported?

3. Is Hanover Insurance Company's denial based on preauthorization supported?

4. Is Hanover Insurance Company's denial based on billing by another provider?

5. Is Injured Workers Pharmacy, LLC entitled to reimbursement for the drugs in question?

Findings

1. Injured Workers Pharmacy, LLC is seeking reimbursement for Ibuprofen and Diclofenac Sodium dispensed November 9, 2023, through May 15, 2024. The insurance carrier denied the services, in part, stating, "Product/Service Not Covered."

   Pharmaceutical services provided through workers' compensation in Texas are covered under 28 TAC §§134.500 through 134.550. DWC finds that the insurance carrier failed to support this denial reason.

2. The insurance carrier denied reimbursement for Diclofenac Sodium dispensed on date of service February 20, 2024, stating, "Claim/Service Denied".

   28 TAC §133.307(d) states, in relevant part:

   > (d) Responses. Responses to a request for MFDR must be legible and submitted to the division and to the requestor in the form and manner prescribed by the division …
   > (2) Response. On receipt of the request, the respondent must provide any missing information not provided by the requestor and known to the respondent. The respondent must also provide the following information and records: …
   > (H) If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier must attach any related Plain Language Notice in accordance with §124.2 of this title.

   No evidence was presented to indicate that the injured employee's claim was denied.

   DWC finds that the insurance carrier failed to provide any support for the denial of payment for the service in question.

3. The insurance carrier denied reimbursement for Ibuprofen dispensed on date of service November 9, 2023, in part, stating, "Prior Authorization required to process this bill."

   Per 28 TAC §134.530(b)(1) and §134.540(b), 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.

   DWC finds that Ibuprofen is not identified with a status of "N" in the applicable edition of the ODG, *Appendix A*. Therefore, this drug does not require preauthorization for this reason.

   The submitted documentation does not support that the drug in question is a compound.

Therefore, this drug does not require preauthorization for this reason.

The submitted documentation does not support that the drug in question is experimental or investigational. Therefore, this drug does not require preauthorization for this reason.

DWC concludes that the insurance carrier's denial of payment of the drug in question based on preauthorization is not supported.

4. The insurance carrier denied payment for Ibuprofen and Diclofenac Sodium dispensed on date of service May 15, 2024, stating, in part, "A reduction was made because a different provider has billed for the exact services on a previous bill."

   The insurance carrier provided no evidence to support this denial reason.

5. Because the insurance carrier failed to support its denial of payment for the drugs in question, Injured Workers Pharmacy LLC is entitled to reimbursement.

   The reimbursement considered in this dispute is calculated according to 28 TAC §134.503(c)(1)(A), with relevant formula for generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount.

Date	Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
11/9/2023	Ibuprofen 800 mg Tablet	59651036205	G	$0.68500	60	$55.38	$55.38	$55.38
2/20/2024	Diclofenac Sodium 1% Gel	70512010610	G	$2.42770	100	$307.46	$307.46	$307.46
3/15/2024	Ibuprofen 800 mg Tablet	59651036205	G	$0.68500	60	$55.38	$55.38	$55.38
4/15/2024	Ibuprofen 800 mg Tablet	59651036205	G	$0.68500	60	$55.38	$55.38	$55.38
4/15/2024	Diclofenac Sodium 1% Gel	70512010610	G	$2.42770	100	$307.46	$307.46	$307.46
5/15/2024	Diclofenac Sodium 1% Gel	70512010610	G	$2.42770	100	$307.46	$307.46	$307.46
5/15/2024	Ibuprofen 800 mg Tablet	59651036205	G	$0.68500	60	$55.38	$55.38	$55.38
							Total	$1,143.90

The total allowable reimbursement is $1,143.90. 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 $1,143.90 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 Hanover Insurance Company must remit to Injured Workers Pharmacy LLC $1,143.90 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 7, 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, please call CompConnection at 1-800-252-7031, option three 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 tres o correo electronico CompConnection@tdi.texas.gov.