



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

TrustRX Pharmacy

Respondent Name

Hartford Insurance Co of Illinois

MFDR Tracking Number

M4-25-2403-01

Carrier's Austin Representative

Box Number 47

DWC Date Received

May 29, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 22, 2024	Left blank	\$1,433.10	\$1,433.10
December 19, 2024	Left blank	\$1,433.10	\$1,433.10
		\$2,866.20	\$2,866.20

Requester's Position

"The following medications have not been paid and still have a remaining balance due... ..Prior authorization was obtained and attached to the reconsideration and still denied."

Amount in Dispute: \$2,866.20

Respondent's Position

The Austin carrier representative for Hartford Insurance Co of Illinois is Burns Anderson Jury & Brenner. The representative was notified of this medical fee dispute on June 2, 2025.

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.

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. [28 TAC §134.530](#) sets out the prior authorization requirements for pharmacy services.
3. [28 TAC §134.503](#) sets out the fee guidelines for pharmacy services.

Denial Reasons

- HE70 – Product/Service Not Covered.
- 60 – B13 – The provider has billed for the exact services on a previous bill.
- ER – P12 – The provider or a different provider has billed for the exact service on a previous bill where no allowance was originally recommended.
- XD – 29 – This bill was submitted after the billing timeliness guidelines provided.

Issues

1. What services are in dispute?
2. Is the insurance carrier's denial supported?
3. What rule(s) is applicable to reimbursement?
4. Is the requester entitled to reimbursement?

Findings

1. The requester did not indicate the services in dispute in Table III on the submitted DWC060. However, the submitted pharmacy medical bills were for only one medication on the disputed dates of service and the explanation of benefits from the insurance carrier was also only for one medication on the disputed dates of service. The services supported by the pharmacy medical bill and the explanation of benefits will be reviewed per applicable DWC fee guideline.
2. The requester seeks reimbursement of the medication Qulipta 60mg for dates of service November 22, 2024 and December 19, 2024. The insurance carrier denied the charges as not covered and duplicate. The insurance carrier did not support these denials.

3. DWC Rule 134.530 (b)(1)(A) states, "Preauthorization for claims subject to the division's closed formulary. Preauthorization is only required for: drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates."

Review of the applicable Appendix A found the medication Qulipta is identified as a "N" drug.

Review of the information submitted found Sedgwick certified the disputed medication under Ref # 5821439 for a quantity of 30 with one refill. The start date was 11/15/2024 the end date 1/15/2025. Based on this review, the disputed "N" drug was authorized with one refill. The insurance carrier's denial is not supported. The service in dispute will be reviewed per the applicable fee guidelines.

DWC Rule 28 TAC §134.503 (c) (1) (A)(B)(C) states in pertinent part, 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 or the billed amount.

- Generic drugs: (AWP per unit) x (number of units) x 1.25) + \$4.00 dispensing fee per prescription = reimbursement amount.

The calculation of the total allowable amount is as follows:

Drug Name	NDC No.	Generic (G) Brand (B)	Price/Unit	AWP	Billed Amount	Lesser of AWP and Billed Amount
Qulipta	00074709430	B	43.70/30	\$1433.10	\$1433.10	\$1433.10

The DWC finds that the requester is entitled to reimbursement in the amount of \$2,866.20. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds TrustRX Pharmacy has established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined Trust Rx Pharmacy is entitled to reimbursement for the disputed services. It is ordered that Hartford Insurance Company must remit to TrustRX Pharmacy 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

August 21, 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. 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.