



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

TrustRX Pharmacy

Respondent Name

Mitsui Sumitomo Insurance Co

MFDR Tracking Number

M4-25-2760-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

July 1, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 9, 2024	Prescription Medication	\$298.44	\$298.43

Requester's Position

"Attached to this submission are copies of the original bills, corresponding Explanation of Benefits (EOBs) reflecting denials, and the reconsideration requests with their respective responses. These documents are provided to support the dispute and demonstrate that appropriate billing and appeal processes have been followed."

Amount in Dispute: \$298.44

Respondent's Position

The Austin carrier representative for Mitsui Sumitomo Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on July 3, 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 §134.503](#) sets out the fee guidelines for pharmacy services.
3. [28 TAC §134.530](#) sets out the requirements of prior authorization of pharmacy services.

Denial Reasons

- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 2 – Bill is denied; invalid / missing healthcare provider license number. Please re-submit with appropriate license number for review.
- 3 – Bill is denied; invalid / missing referring provider license number. Please re-submit with appropriate license number for review.
- P12 – CARC – Workers' compensation jurisdictional fee schedule adjustment.
- 18 – Duplicate claim/service.
- 62 – No proof of pre-auth

Issues

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

Findings

1. The requester submitted a DWC060 for services rendered in December of 2024. The section that requires description of the treatment or services in dispute was left blank. The services that are in dispute will be determined by the amount in dispute, submitted pharmacy bill and explanation of benefits. The service in dispute was found to be.
 - Duloxetine 30mg, Date of Service, December 27, 2024, amount billed \$298.44.

2. The insurance carrier originally denied the claim for missing information and upon reconsideration denied for lack of prior authorization. DWC Rule 134.530(b)(1)(A) states, 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... Review of the applicable Appendix A found the disputed medication is listed as a "Y" drug. The insurance carrier's denial is not supported.
3. The service in dispute will be reviewed per the applicable fee guidelines. 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
Duloxetine	68180029503	G	7.85 30 units	\$298.43	\$298.44	\$298.43

4. The DWC finds that the requester is entitled to reimbursement in the amount of \$298.43.

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 the TrustRX has established that reimbursement of \$298.43 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that Mitsui Sumitomo Insurance Co must remit to TrustRX \$298.43 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____ August 27, 2025

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.