



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

TrustRx Pharmacy

Respondent Name

AIU Insurance Co

MFDR Tracking Number

M4-25-1398-01

Carrier's Austin Representative

Rep Box 19

DWC Date Received

February 25, 2025

Summary of Findings

Dates of Service	Disputed Services		Amount in Dispute	Amount Due
January 19, 2024	NDC # 16714-0661-02	Gabapentin	\$23.96	\$0.00
January 19, 2024	NDC # 70010-0754-01	Methocarbamol	\$23.05	\$0.00
January 19, 2024	NDC # 57896-0201-10	Acetaminophen	\$4.99	\$0.00
March 22, 2024	NDC # 70010-0161-05	Acetaminophen	\$7.02	\$7.02
March 22, 2024	NDC # 50228-0179-10	Gabapentin	\$24.00	\$24.00
March 22, 2024	NDC # 69584-0611-10	Methocarbamol	\$22.86	\$22.86
August 8, 2024	NDC # 00904-6720-60	Acetaminophen	\$12.30	\$10.09
August 8, 2024	NDC # 50228-0179-10	Gabapentin	\$24.00	\$24.00
August 8, 2024	NDC # 51672-3020-02	Lidocaine Oint. 5%	\$1,718.20	\$1,718.20
October 4, 2024	NDC # 00904-6720-60	Acetaminophen	\$12.30	\$10.09
October 4, 2024	NDC # 50228-0179-10	Gabapentin	\$24.00	\$24.00
October 4, 2024	NDC # 33342-0405-30	Lidocaine Oint. 5%	\$1,718.20	\$1,718.20
Total			\$3,614.88	\$3,558.46

Requestor's Position

"I have attached the Bill for DOS 01/19/24 for processing of payment. Please review-and re-process for payment."

Amount in Dispute: \$3,614.88

Respondents' Position

"The carrier asserts that Medical Fee Dispute Resolution is the wrong venue. The bills have been disputed based on extent of injury. We have attached the PLN11."

Received by: Broadspire on behalf of AIU Insurance

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.
4. 28 Texas Administrative Codes [§§134.530](#) and [134.540](#) sets out the closed formulary requirements, effective January 17, 2011, 35 TexReg 11344.

Denial Reasons

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

- W3 - In accordance with TDI-DWC RULE 134.804, this bill has been identified as a request for reconsideration or appeal.
- D49 - Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
- D00 - Based on further review, no additional allowance is warranted.
- 790 - This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
- C79 - Medication reviewed.
- P12 - Workers' compensation jurisdictional fee schedule adjustment.
- D53 – Extent of injury not finally adjudicated.

- 350 - Bill has been identified as a request for reconsideration or appeal.
- 91 - Dispensing fee adjustment.
- G01 - This item was priced as a generic prescribed drug.
- G10 - This services was priced at submitted charges.

Issues

1. Is the requestor eligible for medical fee dispute resolution review for date of service January 19, 2024?
2. Did the insurance carrier raise a new issue after the submission of the medical fee dispute?
3. Is insurance carrier's preauthorization denial reason supported?
4. Is the requester entitled to additional reimbursement?

Findings

1. The requestor seeks payment in the amount of \$52.00 for medications dispensed on January 19, 2024. The medical fee dispute was received by the Division on February 25, 2025.

Per 28 TAC §133.307 (c)(1), the requestor must request medical fee dispute resolution within one year from the date of service, unless a related compensability, extent of injury, or liability dispute exists; or a dispute regarding medical necessity has been filed. If these exceptions apply, a request for medical fee dispute resolution must be filed within 60 days after the date the requestor receives the final decision.

The DWC received the medical fee dispute resolution request on February 25, 2025. This is more than one year after the date of service January 19, 2024. DWC found no evidence to support that an exception applied to this date of service.

A review of the submitted documentation finds that the medications dispensed on January 19, 2024; Gabapentin, Methocarbam, and Pain relief tablets do not involve issues identified in 28 TAC §133.307 (c) (1) (B). The DWC concludes that the requestor has failed to timely file date of service January 19, 2024, with the Division; consequently, the requestor has waived the right to medical fee dispute resolution.

2. The requestor is seeking reimbursement for medications dispensed on March 22, 2024, through October 4, 2024. The insurance carrier in their position statement states in part, "The carrier asserts that Medical Fee Dispute Resolution is the wrong venue. The bills have been disputed based on the extent of injury. We have attached the PLN11."

Rule §133.307(d)(2)(F) requires that: The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

Pursuant to Rule §133.307(d)(2)(F), the insurance carrier's failure to give notice to the health care provider of specific codes or explanations for reduction or denial of payment as

required by Rule §133.240.

The Division of Workers' Compensation (DWC) has determined that the respondent has introduced new denial reasons or defenses. It has been established that the insurance carrier failed to provide notice to the health care provider during the medical bill review process and did not do so prior to the initiation of this dispute. As a result, the DWC concludes that the insurance carrier has forfeited the right to introduce any new denial reasons or defenses during the dispute resolution process. Therefore, any such new defenses or denial reasons will not be considered in this review.

3. The requestor is seeking reimbursement in the amount of \$3,614.88 for medication(s) dispensed on several dates from March 22, 2024, through October 4, 2024. Submitted documentation indicates that the insurance carrier denied the disputed drugs based on preauthorization. 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.

The DWC finds that the drugs in question are identified with a status of "Y" in the applicable edition of the ODG, Appendix A. Therefore, these drugs do not require preauthorization for this reason. The DWC concludes that the insurance carrier's denial of payment of the disputed drug based on preauthorization is supported.

4. 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: $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.25) + \$4.00 \text{ dispensing fee per prescription} = \text{reimbursement amount}$;

Date	Drug	NDC	Generic(G) / Brand(B)	Price / Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed Amt
3/22/24	Acetaminophen	70010016105	G	0.05384	45	\$7.03	\$7.02	\$7.02
3/22/24	Gabapentin	50228017910	G	0.53325	30	\$24.00	\$24.00	\$24.00
3/22/24	Methocarbamol	69584061110	G	0.50290	30	\$22.86	\$22.86	\$22.86
8/8/24	Acetaminophen	00904672060	G	0.05410	90	\$10.09	\$12.30	\$10.09
8/8/24	Gabapentin	50228017910	G	0.53325	30	\$24.00	\$24.00	\$24.00
8/8/24	Lidocaine Oint 5%	51672302002	G	7.61867	180	\$1,718.20	\$1,718.20	\$1,718.20
10/4/24	Acetaminophen	00904672060	G	0.05410	90	\$10.09	\$12.30	\$10.09
10/4/24	Gabapentin	50228017910	G	0.53325	30	\$24.00	\$24.00	\$24.00
10/4/24	Lidocaine Oint 5%	33342040530	G	7.61867	180	\$1,718.20	\$1,718.20	\$1,718.20
TOTAL						\$3,610.47	\$3,614.88	\$3,558.46

The total reimbursement is \$3,558.46. 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 reimbursement of \$3,558.46 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 the respondent must remit to the requestor \$3,558.46 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	May 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, 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.