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
TrustRx Pharmacy

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-25-1873-01

Carrier's Austin Representative
Rep Box 19

DWC Date Received
April 14, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 27, 2024	NDC # 16714-0171-01 / Tizanidine HCl	$141.46	$141.46
January 22, 2025	NDC # 55111-0179-15 / Tizanidine HCl	$141.46	$141.46
February 19, 2025	NDC # 55111-0179-15 / Tizanidine HCl	$141.46	$141.46
	Total	$424.38	$424.38

Requestor's Position

"Attached to this fax is a copy of the original bills that were sent to carrier SEDGWICK along with the appeal for medication TIZANIDINE."
Amount in Dispute: $424.38

Respondents' Position

"The provider has attached its DWC 66S with its DWC 60 packet. We are attaching a copy of the carrier's EOR for each date of service. The carrier's position is that the medications required preauthorization. They were not preauthorized and thus, the provider is not entitled to any reimbursement."
Received by: Flahive, Ogden & Latson

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:

- 5264 – Payment is denied-service not authorized.
- 197 – Payment denied/reduced for absence of precertification/authorization.

Issues

1. Is insurance carrier's denial reason(s) supported?

2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement in the amount of $424.38 for medications dispensed on November 27, 2024, January 22, 2025, and February 19, 2025.

   A review of the 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 drugs based on preauthorization is not supported.

Based on the documentation provided, DWC finds that the carrier failed to sufficiently support the denial 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: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

Date	Drug	NDC	Generic (G)	Price/ Unit	Units Billed	AWP Formula	Billed Amt.	Lesser of AWP/Billed Amount
Nov. 27, 2024	Tizanidine 2mg	16714017101	G	1.22187	90	$141.46	$141.46	$141.46
Jan. 22, 2025	Tizanidine 2mg	55111017915	G	1.22187	90	$141.46	$141.46	$141.46
Feb. 19, 2025	Tizanidine 2mg	55111017915	G	1.22187	90	$141.46	$141.46	$141.46
					Total	$424.38	$424.38	$424.38

The total reimbursement is $424.38. 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 $424.38 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 $424.38 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 8, 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 electronico CompConnection@tdi.texas.gov.