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
Ace American Insurance Company

MFDR Tracking Number
M4-25-1874-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
April 14, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 3, 2024	NDC # 57896-0268-01 / Acetaminophen	$14.79	$14.79
July 3, 2024	NDC # 50228-0179-10 / Gabapentin	$24.00	$24.00
July 3, 2024	NDC # 00406-0484-01 / APAP/COD #3	$30.75	$30.75
	Total	$69.54	$69.54

Requestor's Position

"This claim was denied without a specific reason. All of the prescribed medications are a 'Y' status on the Texas ODG and do not require authorization."

Amount in Dispute: $69.54

Respondent's Position

"Our position remains that the provider is not entitled to reimbursement."

Response Submitted 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).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.503 sets out the fee guidelines for pharmaceutical services.

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 services previously processed electronically, and reimbursement/denial decision previously rendered.

Issues

1. Is the insurance carrier's denial reason supported?
2. What rules apply to disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The requester is seeking reimbursement for prescription medication dispensed on July 3, 2024. The insurance carrier denied coverage for these medications, citing denial code: "HEA1 – Claim/service denied."

   The insurance carrier states in pertinent part, "We are attaching a copy of the EOBs dated August 26, 2024 and November 22, 2024. Our position remains that the provider is not entitled to reimbursement."

   28 TAC §133.305(b) states that if a dispute over the extent of a covered work injury exists for the same service for which there is a medical fee dispute, the dispute regarding the extent of injury shall be resolved prior to the submission of a medical fee dispute.

   Review of the documents submitted by the parties finds that the carrier did not provide documentation to the Division to support that it filed a Plain Language Notice (PLN) regarding the disputed conditions as required by §133.307(d)(2)(H).

The division determines that the respondent failed to provide sufficient information to MFDR to demonstrate that the PLN was ever presented to the requestor or that the requestor was informed of the PLN before the filing date of the medical fee dispute resolution request. The service in dispute does not involve an unresolved extent of injury issue; therefore, this matter is eligible for the adjudication of a medical fee under 28 TAC §133.307.

2. The requester is seeking reimbursement for prescription medication dispensed on July 3, 2024. Because the insurance carrier's denial of payment is not supported, the service in dispute is reviewed pursuant to the applicable fee guidelines.

   Rule 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.

The calculation of the total allowable amount is as follows:

Drug	NDC	Generic(G) Brand(B)	Price/ Unit	Units Billed	AWP Formula	Billed Amount	Lesser of AWP and Billed
Acetaminophen/ codeine	00406048401	G	1.42670	15	$30.75	$30.75	$30.75
Gabapentin	50228017910	G	0.53325	30	$24.00	$24.00	$24.00
Acetaminophen ER	57896026801	G	0.09590	90	$14.79	$14.79	$14.79
				TOTAL	**$69.54**	**$69.54**	**$69.54**

3. The DWC finds that the requestor is entitled to reimbursement in the amount of $69.54. Therefore, this amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies on the relevant evidence the requester and respondent present at the time of adjudication. Although all the evidence in this dispute may not have been discussed, it was considered.

The DWC finds the requester has established that reimbursement is due. As a result, the amount ordered is $69.54.

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 the Respondent must remit to the Requester the amount of $69.54 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 14, 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 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 512-804-4812.