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
AIU Insurance Co

MFDR Tracking Number
M4-25-2482-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
June 6, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 27, 2024	Left blank	$501.05	$501.05
September 11, 2024	Left blank	$636.05	$636.05
October 21, 2024	Left blank	$501.05	$501.05
		$1,638.15	$1,638.15

Requestor's Position

"Attached to this Medical Fee Dispute Resolution request are the following. Copy of the original Bill(s) sent to the carrier. Copy of the original denial. Copy of the appeals that were sent to the carrier (regarding original denial). Copy of denials after appeal were processed. These medications were paid before and after the date in question."

Amount in Dispute: $1,638.15

Respondents' Position

The Austin carrier representative for AIU Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on June 9, 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 §133.10 sets out the required elements of medical bills.
3. 28 TAC §134.503 sets out the fee guidelines for pharmacy services.

Denial Reasons

- Resubmit bill with appropriate ICD-10 diagnosis codes: T14.90 is invalid
- 146 – Diagnosis was invalid for the date(s) of service reported.
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- Bill is denied; invalid/missing healthcare provider license number. Please re-submit with appropriate license number for review.
- 18 – Duplicate claim/service.
- 2 – This procedure on this date was previously reviewed.

Issues

1. Are the insurance carrier's denials supported?

2. What rule is applicable to reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement pharmacy services rendered on August 27, 2024, September 11, 2024 and October 21, 2024. The insurance carrier denied the services for reasons discussed below.

    - Diagnosis was invalid for the date(s) of service reported. DWC Rule 133.10 (f)(3)(A) – (AA) sets out the requirements of pharmacy bill (DWC 66). A diagnosis code is not one of the required elements. Insufficient evidence was found to support how the invalid diagnosis found on the explanation of benefits resulted as the submitted DWC66 submitted with the request for MFDR did not require/contain a diagnosis code.
    - Missing health care provider license number. DWC Rule 133.10(f)(3)(A)-AA does not specify a license number is required on pharmacy bills.
    - These denials are not supported and will not be considered in this review.

2. DWC Rule 28 Texas Administrative Code §134.503 (c)(1)(A)(B) states in pertinent part (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

    (1) 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:

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

    (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;

Date of Service	Drug	NDC	Generic(G) Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
8/27/2024	Ibuprofen	73086021201	G	$4.418	90	$501.05	$501.05	$501.05
9/11/2024	Pregabalin	72205001300	G	$8.427	60	$636.05	$636.05	$636.05
10/21/2024	Ibuprofen	73086021201	G	$4.418	90	$501.05	$501.05	$501.05

3. The total reimbursement calculation is based on the MAR for the medications listed above. The recommended payment amount is $1,638.15.

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 TrustRX Pharmacy has established that reimbursement of $1,638.15 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 AIU Insurance Co must remit to TrustRX Pharmacy $1,638.15 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		August 26, 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 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.