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

Requester Name
TrustRX Pharmacy

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-25-2547-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
June 12, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 18, 2024	Left blank	$52.50	$52.50
December 13, 2024	Left blank	$101.00	$101.00
January 8, 2025	Left blank	$101.00	$101.00
February 7, 2025	Left blank	$111.79	$111.78
March 6, 2025	Left blank	$111.79	$111.78
		$478.08	$478.06

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 document are provided to support the dispute and demonstrate the appropriate billing and appeals processes have been followed."

Amount in Dispute: $478.08

Respondent's Position

"Respondent has disputed the bills at issue in this matter as Requester did not include any compensable diagnosis codes, nor did they provide any documentation to support they were treating the compensable injury. Therefore, all bills were denied based on extent of injury."

Response submitted by: Downs Stanford P.C.

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 §133.240 sets out the requirements of medical bill processing.
3. Texas Administrative Code §19.2009 sets out the requirements of utilization review.
4. 28 TAC §124.2 sets out the notification requirements by insurance carriers.
5. 28 TAC §134.503 sets out the fee guidelines for pharmacy services.
6. 28 TAC §134.530 defines the requirements of prior authorization for medication.

Denial Reasons

- The denial reasons are discussed below in "Findings".

Issues

1. Did the insurance carrier follow the appropriate administrative process to address denial of no medical support?
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 seeks reimbursement of the following medication (Etodolac Cap 200mg) for dates of service ranging form September of 2024 to March of 2025.

   The insurance carrier denied the disputed charges for the following reasons.

   - Date of service September 18, 2024. Explanation of benefits processed December 26, 2024.
     - Cannot review bill without medical notes for dates of services
     - Information requested from the billing/rendering provider was not provided or not provide timely or was insufficient/incomplete.
   - Date of service September 18, 2024. Explanation of benefits processed February 5, 2025.
     - 193 – Original payment decision is being maintained.

    - P4 – Workers' compensation claim adjudicated as non-compensable. This payer not liable for claim or service/treatment.
    - N612 – Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction.
- Date of service September 18, 2024. Explanation of benefits processed April 30, 2025
    - W3 – Bill is reconsideration or appeal.
- Date of service December 13, 2024. Explanation of benefits reviewed January 7, 2025
    - HEA1 – Claim/Service denied.
- Date of service December 13, 2024. Explanation of benefits reviewed February 4, 2025
    - 5204 – Payment is denied-service not authorized.
    - 197 – Payment denied/reduced for absence of precertification/authorization.
- Date of service December 19, 2024. Explanation of benefits processed April 30, 2025
    - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
    - 29 – The time limit for filing claim/bill has expired.
    - W3 – Bill is a reconsideration or appeal.
- Date of service January 8, 2025. Explanation of benefits with audit date of January 22, 2025.
    - HEA1 – Claim/service denied.
- Date of service January 8, 2025. Explanation of benefits with audit date of April 28, 2025.
    - 4271 – Per TX Labor Code Sec. 408.027, providers must submit bills to payors within 95 days of the date of service.
    - 197 – Payment denied/reduced for absence of precertification/authorization.
    - 29 – The time limit for filing claim/bill has expired.
- Date of service February 7, 2025. Explanation of benefits processed by vendor February 18, 2025.
    - 5085 – Payment is denied as billed diagnosis is not allowed in this claim
    - 96 – Non-covered charge(s).
    - N569 – Not covered when performed for the reported diagnosis.
- Date of service February 7, 2025. Explanation of benefits processed by vendor April 30, 2025.
    - 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
    - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
    - W3 – Bill is a reconsideration or appeal.

- Date of service March 6, 2025. Explanation of benefits processed by vendor March 19, 2025.
    - 5085 is denied as the billed diagnosis is not allowed in this claim
    - 5264 – Payment is denied-service not authorized.
    - 197 – Payment denied/reduce for absence of precertification/authorization.
    - 96 – Non-covered charge(s).
- Date of service March 6, 2025. Explanation of benefits processed by vendor May 5, 2025.
    - 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
    - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
    - W3 – Bill is a reconsideration or appeal.

DWC Rule 28 Texas Administrative Code §133.240 (q) states, in relevant part, "When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title ...

Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title …, including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor ..."

Submitted documentation does not support that the insurance carrier followed the appropriate procedures for a retrospective review denial of the disputed services outlined in §19.2003 (b)(31) or §133.240 (q) when denying for diagnosis and non-covered service.

Therefore, the insurance carrier did not appropriately raise medical necessity for this dispute and this denial reason will not be considered in this review.

The denial for timely filing was made after reconsideration. Insufficient evidence was found to support the request for reconsideration met the definition of a "new" or "corrected" bill. This denial is not supported.

The insurance carrier denied some of the dates of service as not being prior authorized. DWC Rule 134.530 (b)(1)(A) states in pertinent part, "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 medication (Etodolac Cap 200mg) to be listed as a "Y" drug. Prior authorization was not required.

The denial reasons listed above are not supported. The services in dispute will be reviewed per applicable fee guidelines.

2. The insurance carrier responded to this request for MFDR with the following statement, "…Requester did not include any compensable diagnoses codes, nor did they provide any documentation to support they were treating the compensable injury. Therefore, all bills were

denied based on extent of injury.

DWC Rule 28 TAC §133.307(d)(2)(H) requires that if the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with Rule §124.2 (relating to carrier reporting and notification requirements).

DWC Rule 28 TAC §124.2(h) requires notification to the division and claimant of any dispute of disability or extent of injury using plain language notices with language and content prescribed by the division. Such notices "shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim."

Review of the submitted information finds no copies, as required by Rule §133.307(d)(2)(H), of any PLN-11 or PLN 1 notices issued in accordance with Rule §124.2. The insurance carrier's denial reason is therefore not supported. Furthermore, because the respondent failed to meet the requirements of Rule §133.307(d)(2)(H) regarding notice of issues of extent of injury, the respondent has waived the right to raise such issues during dispute resolution. Consequently, the division concludes there are no outstanding issues of compensability, extent, or liability for the injury. The disputed services are therefore reviewed pursuant to the applicable rules and guidelines.

3. 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;

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Etodolac 200mg 9/18/2024	62559025001	G	1.293	30	$52.50	$52.50	$52.50
Etodolac 200mg 12/13/2024	62559025001	G	1.293	60	$101.01	$101.00	$101.00
Etodolac 200mg 1/8/2025	62559025001	G	1.293	60	$101.01	$101.00	$101.00
Etodolac 200mg 2/7/2025	60505003901	G	1.437	60	$111.78	$111.79	$111.78
Etodolac 200mg 3/6/2025	60505003901	G	1.437	60	$111.78	$111.79	$111.78

4. The total reimbursement is $478.06, this amount is recommended.

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 requester has established that reimbursement 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 Indemnity Insurance Co of North America must remit to Trust RX Pharmacy $478.06 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130

Authorized Signature

		July 9, 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.