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
AIU Insurance Co

MFDR Tracking Number
M4-25-2577-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
June 17, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 21, 2024	Not specified	$118.28	$118.28
December 18, 2024	Not specified	$118.28	$118.28
		$236.56	$236.56

Requester's Position

"This is a "Y" status medication and does not require prior authorization."

Amount in Dispute: $236.56

Respondent's Position

The Austin carrier representative for AIU Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on June 18, 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 §134.503 sets out the fee guidelines for pharmacy services.

Denial Reasons

- HE75 – Prior authorization required to process this bill.
- (Illegible) – The related or qualifying claim/service was not identified on this claim.
- 60 (B13) – The provider has billed for the exact services on a previous bill.
- (Illegible) – Claim/Service lacks information which is needed for adjudication.

Issues

1. Is the insurance carrier's denial supported?
2. What rule is applicable to reimbursement?
3. Is the requester entitled to reimbursement?

Findings

1. The requester seeks reimbursement of the following medications (based on submitted DWX066 pharmacy bills).
   - November 21, 2024 / Naproxen – NDC 50228-0436-01 30 units $52.77
   - November 21, 2024 / Cyclobenzaprine – NDC 16571-0783-10 30 units $65.52
   - December 18, 2024 / Cyclobenzaprine – NDC 16571-0783-10 30 units $65.52
   - December 18, 2024 / Naproxen – NDC 50228-0436-01 30 units $52.76

   The insurance carrier denied the disputed services for lack of prior authorization, lacking information and duplicate.

   DWC Rule §134.350 (b) states in pertinent parts,

   Preauthorization for claims subject to the division's closed formulary.

   (1) Preauthorization is only required for:

   (A) 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, and

any updates;

(B) any prescription drug created through compounding; and

(C) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but that is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

Review of the applicable Appendix A found neither medication on these dates of service required prior authorization. These medications are not considered compounded medication nor are they investigational.

The insurance carrier's denial for prior authorization is not supported. The denials for lack of information and duplicate were not supported by additional documentation or in a position statement and will not be considered in this review.

2. The service in dispute will be reviewed per the applicable fee guidelines. 28 TAC §134.503 (c) (1) (A)(B)(C) states in pertinent part, 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 or the billed amount.

   (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;

   The calculation of the total allowable amount is as follows:

Drug Name	NDC No.	Generic (G) Brand (B)	Price/Unit	AWP	Billed Amount	Lesser of AWP and Billed Amount
Naproxen	50228043601	G	1.30/30	$52.76	$52.76	$52.76
Cyclobenzaprine	16571078310	G	1.64/30	$65.52	$65.52	$65.52

3. The DWC finds that the requester is entitled to reimbursement in the amount of $118.28 for the dates of service November 21, 2024 and December 18, 2024 for a total recommended allowance of $236.56.

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 additional 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 AIU Insurance Co must remit to TrustRX Pharmacy $236.56 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		November 24, 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.