



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

TrustRX Pharmacy

Respondent Name

Indemnity Insurance Co of North America

MFDR Tracking Number

M4-25-2582-01

Carrier's Austin Representative

Box Number 15

DWC Date Received

June 18, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 23, 2024	Left blank (Prescription Medication)	\$90.88	\$90.88
January 21, 2025	Left blank (Prescription Medication)	\$90.88	\$90.88
February 18, 2025	Left blank (Prescription Medication)	\$65.52	\$65.52
March 18, 2025	Left blank (Prescription Medication)	\$89.51	\$89.50
April 17, 2025	Left blank (Prescription Medication)	\$89.51	\$89.50
		\$426.30	\$426.28

Requester's Position

"...Prior authorization is not required for the following medications per the Texas ODG form. These are "Y" status medication and do not require prior authorization."

Amount in Dispute: \$426.30

Respondent's Position

The Austin carrier representative for Indemnity Insurance Co of North America is Downs Stanford PC. The representative was notified of this medical fee dispute on June 23, 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 §124.2](#) sets out the notice requirements from insurance carriers.
3. [28 TAC §133.240](#) sets bill audit requirements by insurance carriers.
4. [TLC §19.2010](#) sets out the requirements of utilization review under workers' compensation.
5. [28 TAC §134.503](#) sets out the fee guidelines for pharmacy services.
6. [28 TAC §134.530](#) sets out the requirements of prior authorization for medications.

Denial Reasons

- 5264 – Payment is denied service not authorized.
- 197 – Payment denied/reduced for absence of precertification/authorization.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 947 – Upheld. No additional allowance has been recommended.
- 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.
- Service reviewed per claims examiner instructions.
- 219 – Based on extent of injury.
- HEA1 – Claim/service denied.
- 18 – Exact duplicate claim/service.
- HEMD – These are non-covered services because this is not deemed a 'medical necessity' by the payer.

Issues

1. What services are in dispute?
2. Is the insurance carrier's denial(s) supported?
3. What rule is applicable to reimbursement?
4. Is the requester entitled to reimbursement?

Findings

1. The requester submitted a DWC060 request form for pharmacy services but left the section titled, "Treatment or Service Codes in Dispute" blank. Based on the submitted pharmacy bills and explanation of benefits the following medications are in dispute on the dates of service indicated.
 - December 23, 2024 amount in dispute listed, \$90.88
 - Cyclobenzaprine \$65.52
 - Gabapentin \$25.36
 - January 21, 2025 amount in dispute listed, \$90.88
 - Cyclobenzaprine \$65.52
 - Gabapentin \$25.36
 - February 18, 2025 amount in dispute listed, \$65.52
 - Cyclobenzaprine \$65.52
 - March 18, 2025 amount in dispute listed \$89.51
 - Cyclobenzaprine \$65.52
 - Gabapentin \$23.99
 - April 17, 2025 amount in dispute listed \$89.51
 - Cyclobenzaprine \$65.52
 - Gabapentin \$23.99

The service in dispute will be reviewed per the applicable fee guidelines.

2. The insurance carrier denied the medications for the primary reasons found below.
 - Lack of prior authorization. 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 none of the medication listed above are "N" drugs but rather "Y" drugs. This denial is not supported.
 - Extent of injury. 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).

28 TAC §124.2(h) requires notification to the division and claimant of any dispute of disability or the 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 the 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.

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

3. 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.

Generic drugs: $(\text{AWP per unit}) \times (\text{number of units}) \times 1.25 + \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
Cyclobenzaprine	16571078310	G	1.64 30 units	\$65.52	\$65.52	\$65.52
Gabapentin	23155086610	G	.53 30 units	\$23.98	\$23.99	\$23.98
Gabapentin	70010010810	G	.569 30 units	\$25.37	\$25.36	\$25.36

4. The DWC finds that the requester is entitled to reimbursement for the disputed dates of service as follows.

- December 23, 2024, \$90.88
- January 21, 2025, \$90.88
- February 18, 2025, \$65.52
- March 18, 2025, \$89.50
- April 17, 2025, \$89.50
- Total amount due to the requester is \$426.28. 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 TrustRX Pharmacy has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the Trust is entitled to reimbursement for the disputed services. It is ordered that Indemnity Insurance Co of North America must remit to Trust RX Pharmacy \$426.28 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

August 26, 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, 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 electrónico CompConnection@tdi.texas.gov.