



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

TrustRX Pharmacy

Respondent Name

Ace American Insurance Co

MFDR Tracking Number

M4-25-2596-01

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 31, 2024	Left blank	\$422.98	\$422.98
January 28, 2025	Left blank	\$422.98	\$422.98
February 27, 2025	Left blank	\$422.98	\$422.98
March 26, 2025	Left blank	\$422.98	\$422.98
		\$1,691.92	\$1,691.92

Requester's Position

"Attached to this Medicare 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 the denials after appeal were processed."

Amount in Dispute: \$1,691.92

Respondent's Position

The Austin carrier representative for Ace American Insurance Co 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 §134.503](#) sets out the fee guidelines for pharmacy services.

Denial Reasons

- 197 – Precertification/authorization/notification absent.
- 2 – Payment denied – Unauthorized provider or facility.
- 18 – Duplicate claim/service.
- 1 – Request for reconsideration reviewed. Please contact claim examiner.

Issues

1. What service is in dispute?
2. Was prior authorization required?
3. What rule is applicable to reimbursement?
4. Is the requester entitled to reimbursement?

Findings

1. The requester submitted a request for MFDR for dates of service December 31, 2024, January 28, 2025, February 27, 2025 and March 26, 2025 each with an amount in dispute of \$422.98. The requester neglected to complete the section of the DWC060 that asks for the treatment and service codes in dispute. The division will review the submitted pharmacy bills and explanation of benefits to determine the medication in dispute.
2. After reviewing the submitted pharmacy bill, the medication dispensed on each of the dates of service listed above is Ciprofloxacin 500mg, NDC 59651086701. The insurance carrier denied the claim for lack of prior authorization and unauthorized provider. DWC Rule 28 TAC §134.530(2)(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... Review of the applicable Appendix A for the disputed date of service

found this medication is listed as a "Y" drug. The insurance carrier's denial is not supported. The insurance carrier did not respond to this request for MFDR with a position statement that could explain their denial for unauthorized provider. As no documentation was presented to support this denial, the denial for unauthorized provider is not supported. The medication Ciprofloxacin will be reviewed per applicable pharmacy fee guideline.

3. DWC Rule 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: $(AWP \text{ per unit}) \times (\text{number of units}) \times 1.25 + \$4.00 \text{ dispensing fee per prescription} = \text{reimbursement amount.}$

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
Ciprofloxacin	59651086701	G	5.586/60	\$422.98	\$422.98	\$422.98

4. The DWC finds that the requester is entitled to reimbursement in the amount of \$1,691.92. 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 requester is entitled to reimbursement for the disputed services. It is ordered that Ace American Insurance Co must remit to TrustRX Pharmacy \$1,691.92 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 29, 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.