



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

TrustRX Pharmacy

Respondent Name

LM Insurance Corp

MFDR Tracking Number

M4-25-2599

Carrier's Austin Representative

Box Number 60

DWC Date Received

June 19, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 20, 2024	Pharmaceutical Services	\$128.94	\$0.00
October 14, 2024	Pharmaceutical Services	\$129.62	\$0.00
November 11, 2024	Pharmaceutical Services	\$129.08	\$0.00
Total		\$387.82	\$0.00

Requester's Position

"DOS 6/20/24 ... TRAMADOL \$128.94 was appealed with the prior authorization was attached and still denied.

"DOS 10/14/24 ... TRAMADOL \$129.62 was appealed with the prior authorization was attached and still denied.

"DOS 11/11/24 ... TRAMADOL \$129.08 was appealed with the prior authorization was attached and still denied."

Supplemental Statement: "I noticed that payments for the following dates of service were issued to Injury Billing LLC:

- DOS 6/20/2024 - \$128.94
- DOS 10/14/2024 - \$129.62

"... Trustrx had already provided formal notice of the termination of our relationship with Injury Billing LLC prior to the issuance of these payments."

Supplemental Statement: "Per the last reconsideration submitted on 4/28/25 for dates of service 6/20/24 and 10/14/24, along with the Medical Fee Dispute, please note that Trustrx Pharmacy had formally terminated its relationship with Injury Billing LLC prior to the issuance of payment."

Amount in Dispute: \$387.82

Respondent's Position

"The bill has been reviewed and adjusted for payment – copies of EOBs are submitted for your review."

Supplemental Statement: "Payment was a direct deposit."

Response Submitted by: Liberty Mutual Insurance

Findings and Decision

Authority

This medical fee dispute is decided according to [Texas Labor Code \(TLC\) §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. [28 Texas Administrative Code \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.

Denial Reasons

The insurance carrier denied payment for the disputed services with the following claim adjustment codes:

- 4121 – Preauthorization is required for drugs identified with a status of "N" in the current edition of the "Official Disability Guidelines Treatment in Workers' Comp" (ODG)Appendix A, "ODG Workers' Compensation Drug Formulary" and any updates.
- 197
- U301 – This item has been reviewed on a previously submitted bill, or is currently in process. Notification of decision has been previously provided or will be issued upon completion of our review.

Issues

1. Did the insurance carrier maintain its denial of payment for the services in question?

Findings

1. TrustRX is seeking reimbursement for drugs dispensed on June 20, 2024; October 14, 2024; and November 11, 2024. Per explanations of benefits dated July 1, 2025, the insurance carrier paid the requester in full. DWC concludes that the insurance carrier did not maintain its denial of payment and paid the services in full. No additional reimbursement 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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

September 25, 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 three 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 tres o correo electrónico CompConnection@tdi.texas.gov.