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
Ace American Insurance Co

MFDR Tracking Number
M4-25-2684-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
June 24, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 5, 2024	Left blank	$388.37	$388.37
		$388.37	$388.37

Requester's Position

"Attached to this Medical Fee Dispute Resolution request are the following: Copy of the original Bill(s) sent to carrier. Copy of original denials. Copy of appeals that were sent into carrier (regarding original denial). Copy of denials after appeals were processed."

Amount in Dispute: $388.37

Respondent's Position

"The MDR request has been received and the bill was sent back for reconsideration. The response is still pending. On the response is received, an addendum will be filed."

Response submitted by: ESIS

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 §133.10 sets out the requirements of medical bill submission by health care provider.

3. 28 TAC §134.503 sets out the fee guidelines for pharmacy services.

Denial Reasons

- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 2 – Bill is denied invalid / missing healthcare provider license number. Please re-submit with appropriate license number for review.
- 251 – The attachment/other documentation content received did not contain the content required to process this claim or service.
- DAW, DaysSupply and PrescriptionLine # are required to be billed on pharmacy bills. Please resubmit with all appropriate information.
- 3 – This procedure on this date was previously reviewed.
- 18 – Duplicate claim/service.

Issues

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

Findings

1. The requester sent in a request for MFDR that did not indicate the treatment or service codes in dispute. This DWC060 indicates a date of service December 5, 2024 and amount of $388.37 in dispute. The submitted documentation contained pharmacy (DWC66) bills and explanation of benefits for the following medications.
    - Cyclobenzaprine Tab 5mg, quantity 30, billed amount $36.30
    - Omeprazole Cap 20mg, quantity 30, billed amount $166.98
    - Meloxicam 15mg, quantity 30, billed amount $185.69

These services are determined to be in dispute and will be reviewed per the applicable fee guidelines.

2. The insurance carrier denied the disputed pharmacy bills as shown above. DWC Rule §133.10 (f)(3)(A-AA) sets out the requirements of a complete pharmacy bill. Review of these requirements does not require the license number of the pharmacy. Regarding the days supply denial. Review of the submitted DWC066 form indicates in box 23 the quantity and in box 24 the days supply for disputed medication on the date of service December 5, 2024. The insurance carrier's denial is not supported.
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.

    (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
Cyclobenzaprine	10702000610	G	1.72/15	$36.30	$36.30	$36.30
Omeprazole	16714063403	G	4.346/30	$166.98	$166.98	$166.98
Meloxicam	29300012510	G	4.845/30	$185.69	$185.69	$185.69

3. The DWC finds the maximum allowable reimbursement is $388.97. The requester is seeking $388.37. 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 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 $388.37 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		September 18, 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.