



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

TrustRX Pharmacy

Respondent Name

New Hampshire Insurance Co

MFDR Tracking Number

M4-25-2732-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

June 30, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 9, 2024	Left blank	\$14.79	\$14.79
January 16, 2025	Left blank	\$334.81	\$334.81
February 19, 2025	Left blank	\$334.81	\$334.81
		\$684.41	\$684.41

Requester's Position

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

Amount in Dispute: \$684.41

Respondent's Position

The Austin carrier representative for New Hampshire Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on July 1, 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

- U301 – MN – 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.
- U301 – OR – This bill is a duplicate of a previously submitted bill. Please refer to original decision, and file appeal as noted on top right corner of this EOP.
- 5917 – Pre-authorization was required, but not requested for the service per DWC Rule 134.600.
- 269 – This billing is for a service unrelated to the work illness or injury.
- 269 – MN – The service(s) is for a condition(s) which is not related to the covered work related injury.
- 269 – NY – Treatment provided was not casually related to the compensable injury.

Issues

1. What services are in dispute?
2. Did the insurance carrier support nonrelated compensability?
3. Was prior authorization required?
4. What rule is applicable to reimbursement?
5. Is the requester entitled to reimbursement?

Findings

1. The requester submitted to MFDR seeking reimbursement for services rendered in December, January and February. The submitted DWC060 section that requires the provider list the treatment and services in dispute was left blank. Therefore, the services to be reviewed were

determined by the amount in dispute, the submitted pharmacy bills and explanation of benefits indicate the following medications are in dispute.

- Acetaminophen, Date of service, December 9, 2024, Amount billed \$14.79
- Pregabalin, Date of service, January 16, 2025, Amount billed \$320.02
- Acetaminophen, Date of service January 16 , 2025, Amount billed \$14.79
- Pregabalin, Date of service, February 19, 2025, Amount billed \$320.02
- Acetaminophen, Date of service February 19, 2025, Amount billed \$14.79

2. The submitted explanation of benefits contained a denial for the services not being related to the compensable work related injury. DWC Rule 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).

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

3. The insurance carrier also denied the services as prior authorization not requested or obtained. DWC Rule 28 TAC §134.530 (b)(1)(A) states in pertinent part, Preauthorization for claims subject to the division's closed formulary. 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, Acetaminophen is a "Y" drug. Pregabalin is a "Y" drug. Prior authorization was not required. The service in dispute will be reviewed per the applicable fee guidelines.
4. 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 per unit) x (number of units) x 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
Acetaminophen	57896026801	G	0.09/90	\$14.79	\$14.79	\$14.79
Pregabalin	72205001390	G	8.427/30	\$320.02	\$320.02	\$320.02

The DWC finds that the requester is entitled to reimbursement in the amount of \$684.41. 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 has established that reimbursement in the amount of \$684.41 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 New Hampshire Insurance Co must remit to TrustRX \$684.41 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.