



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

TrustRX Pharmacy

**Respondent Name**

Sunz Insurance Co

**MFDR Tracking Number**

M4-25-2800-01

**Carrier's Austin Representative**

Box Number 31

**DWC Date Received**

July 7, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 3, 2025	Left blank Prescription Medication	\$501.36	\$434.19
March 3, 2025	Left blank Prescription Medication	\$511.34	\$444.17
March 31, 2025	Left blank Prescription Medication	\$511.34	\$444.17
		\$1,524.04	\$1,322.53

### 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 denial. Copy of the appeals that were sent into the carrier (regarding original denial). Copy of denials after appeal were processed. Reconsideration was sent regarding underpayment and was still denied."

**Amount in Dispute:** \$1,524.04

## Respondent's Position

"We are upholding our original allowance as Brand name drug replaced with generic equivalent based on Fee Schedule guidelines, The NDC code billed is for an Over the Counter (OTC) drug and as such does not warrant a dispensing fee."

**Response submitted by:** COMPiQ

## 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

- 387 – Brand name drug replaced with generic equivalent based on Fee Schedule guidelines.
- 388 – The NDC code billed is for an Over the Counter (OTC) drug and as such does not warrant a dispensing fee.
- ANSI91 – 91 – Dispensing fee
- ANSIP12 – P12 – Workers compensation jurisdictional fee schedule adjustment.
- ANSI193 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – TDI Level I Appeal means a request for reconsideration under 133.250 of this title or an appeal of an adverse determination under Chapter 19, Subchapter U of this title.

### Issues

1. Is the insurance carrier's reduction supported?
2. What rule is applicable to reimbursement?
3. Is the requester entitled to reimbursement?

### Findings

1. TrustRX Pharmacy submitted to MFDR a DWC60 leaving the section that should describe the treatment or services in dispute blank. Copies of pharmacy bills and explanation of benefits for the dates of service were found as indicated below.

- February 3, 2025 – Lidocaine Pad 4%, Generic NDC 71662000020 quantity 30, \$528.81
- March 3, 2025 – Lidocaine Pad 4% Generic NDC 71662000020 quantity 30, \$528.81
- March 3, 2025 – Biofreeze Gel 4% Brand NDC 59316010212 quantity 89.00, \$13.95
- March 31, 2025 – Lidocaine Pad 4% Generic NDC 71662000020 quantity 30, \$528.81
- March 31, 2025 – Biofreeze Gel 4% Brand NDC 59316010212 quantity 89.00, \$13.95

The insurance carrier reduced payment stating that “the charge for the over-the-counter medication exceeds the retail price,” and “Brand name drug replaced with generic equivalent based on Fee Schedule guidelines.”

Per 28 TAC §134.503(d), “Reimbursement for nonprescription drugs or over-the-counter medications must be the retail price of the lowest package quantity reasonably available that will fill the prescription.” Based on the documentation provided by the insurance carrier, DWC found no evidence that the drug in question was an over-the-counter medication, nor did it provide a retail price which could be applied in this case to support its reduction.

In its position statement the insurance carrier referenced Fee Schedule guidelines to support its reduction amount. 28 TAC §134.503 (e) states, in relevant part, “Except as provided by subsection (f) of this section, **if an amount cannot be determined under subsections (c)(1) or (d)** of this section, reimbursement must be an amount that is consistent with the criteria listed in Labor Code §408.028(f), including providing for reimbursement rates that are fair and reasonable.” [emphasis added]. Based on the drug as billed, DWC finds that an amount can be determined under subsection (c)(1). Therefore, the procedures in subsection (e) do not apply.

DWC concludes that the insurance carrier’s reduction reasons are not supported.

Because the insurance carrier failed to support its reduction of payment, DWC will review the disputed drugs for additional reimbursement.

2. The service in dispute will be reviewed per the applicable fee guidelines. 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:  $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.25) + \$4.00 \text{ dispensing fee per prescription} = \text{reimbursement amount.}$

(B) Brand-name drugs:  $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.09) + \$4.00 \text{ dispensing fee per prescription} = \text{reimbursement amount.}$

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
Lidocaine Pad	71662000020	G	\$13.995/30	\$461.64	\$528.81	\$461.64
Biofreeze	59316010212	B	\$0.102/89	\$13.95	\$13.95	\$13.95

3. The DWC finds the fee guideline for the three prescriptions of Lidocaine Pad and two of the Biofreeze are  $(\$461.64 \times 3 = \$1,384.92) + (\$13.95 \times 2 = \$27.90)$  or \$1,412.82.

The carrier paid \$90.29; therefore, the requester is entitled to the remaining amount of \$1,322.53.

### 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 TrustRX Pharmacy has established that additional reimbursement is due.

### **Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the TrustRX Pharmacy is entitled to reimbursement for the services in dispute. It is ordered that Sunz Insurance Co must remit to TrustRX Pharmacy \$1,322.53 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

\_\_\_\_\_  
September 15, 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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).