



Medical Fee Dispute Resolution Findings and Decision General Information

Requester Name

Injured Workers' Pharmacy

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-25-3268-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

August 13, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 10, 2024	52427063230 Venlafaxine	\$106.29	\$106.29
January 6, 2025	52427063230 Venlafaxine	\$35.43	\$35.43
January 31, 2025	52427063230 Venlafaxine	\$35.43	35.43
March 4, 2025	52427063230 Venlafaxine	\$35.43	35.43
April 2, 2025	52427063230 Venlafaxine	\$106.29	\$106.29
Total		\$318.87	\$318.87

Requester's Position

"The attached bills were not paid in full by the carrier. Attached, you'll find email chains where IWP has requested EOBs from the carrier to support the underpayment and them not being able to provide this information. I personally emailed both the internal bill review department at Texas Mutual and Optum, they were unable to assist, and the carrier was not able to provide information to support short payment."

Amount in Dispute: \$318.87

Respondent's Position

"Per rule 133.307(c)(2)(P-Q) (P) if the requestor is a pharmacy processing agent, a signed and dated copy of an agreement between the processing agent and the pharmacy clearly demonstrating the dates of service covered by the contract and a clear assignment of the pharmacy's right to participate in the MFDR process. The pharmacy processing agent may redact any proprietary information contained within the agreement; and (Q) any other documentation that the requestor deems applicable to the medical fee dispute. The pharmacy did not provide a copy of the agreement for the processing agent. Additionally, the bills were processed at the contracted rate through TMESYS LLC, as shown on the explanation of benefits. Our position is that no payment is due."

Response Submitted by: Texas Mutual

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 \(TAC\) §133.305](#) sets out the procedures for resolving medical disputes.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
3. [The Texas Insurance Code \(TIC\) Chapter 1305](#) sets out the general provisions for workers' compensation health care networks.
4. [28 TAC §134.503](#) sets out the fee guidelines for pharmaceutical benefits.
5. [28 TAC §141.1](#) sets out the guidelines for dispute resolution—benefit review conference.
6. [Texas Labor Code §401.011](#) sets out general definitions for the Texas Workers' Compensation Act.
7. [Texas Labor Code §408.0281](#) sets out reimbursement for pharmaceutical services, administrative violations.

Denial Reasons

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

- CAC-45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- PC4 – Payment reduced to Progressive Medical, LLC contract rate.

Issues

1. Is the respondent's position statement supported?
2. What was the billed amount on the submitted pharmacy bills?
3. What rule is applicable to the fee calculation?

Findings

1. The medical fee dispute M4-25-3268-01 pertains to the prescription medication Venlafaxine which was dispensed on the following dates: October 10, 2024; January 6, 2025; January 31, 2025; March 4, 2025; and April 2, 2025. In its response, Texas Mutual presents the following position:
 - No request for Reconsideration. The documentation submitted by the requester includes credible evidence or reconsideration requests for each disputed claim that was paid at a reduced rate.
 - No Explanation of Benefits (EOB). The requester provided copies of email correspondence sent to the carrier requesting EOBs on multiple occasions. The carrier did not respond to these requests.
 - No Copy of Agreement for the Processing Agent. The DWC-60 form submitted for each disputed date of service identifying Injured Workers Pharmacy as the dispensing provider. Therefore, reimbursement should be rendered directly to Injured Workers Pharmacy.
 - Bills Processed at a Contracted Rate Through TMESYS LLC. Texas Mutual processed the claims through TMESYS LLC at a contracted rate. However, according to Section 1305.101, of the Texas Insurance Code, titled *Providing or Arranging for Health Care*, prescription medications, as defined by Section 401.011(19)(E) of the Labor Code, may not, directly or indirectly through a contract, be delivered through a workers' compensation health care network. Instead, reimbursement for prescription medications must be handled in accordance with Section 408.0281 of the Labor Code, the Texas Workers' Compensation Act, and the applicable rules set by the Commissioner of Workers' Compensation.

The Division finds that the medications dispensed by the provider are not subject to network-based reductions. Therefore, the carrier's reduction in payment is not supported. As the insurance carrier failed to justify the reduced payments, the requester is entitled to additional reimbursement for the disputed prescription medications.

2. The Division has reviewed the pharmacy bills related to the disputed pharmacy charges and made the following findings:
 - For Venlafaxine (90 count), the requester listed a billed amount of \$834.22 on the DWC-060. However, the submitted medical bill reflects a billed amount of \$878.13, which will be used for the fee calculation.
 - For Venlafaxine (30 count), the DWC-060 shows a billed amount of \$280.61, while the medical bill lists \$295.38. The amount of \$295.38 will be used in the fee calculation.
3. 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.
 - Generic drugs: $(\text{AWP per unit}) \times (\text{number of units}) \times 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
Venlafaxine	52427063230	G	\$7.77/90	\$878.13	\$878.13	\$878.13
Venlafaxine	52427063230	G	\$7.77/30	\$295.37	\$295.38	\$295.37

The DWC finds that the requester is entitled to reimbursement in the amount of \$2,642.37. The carrier paid \$2,191.40, the requester is seeking an additional payment of \$318.87. This amount is recommended.

Conclusion

The outcome of this medical fee dispute relies on the relevant evidence the requester and respondent present at the time of adjudication. Although all the evidence in this dispute may not have been discussed, it was considered.

The DWC finds the Injured Workers' Pharmacy has established that additional reimbursement of \$318.87 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the Injured Workers' Pharmacy is entitled to reimbursement for disputed services. It is ordered that Texas Mutual Insurance must remit to Injured Workers Pharmacy \$318.87 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	August 28, 2025
Signature	Medical Fee Dispute 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 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.