



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

TrustRX Pharmacy

Respondent Name

Ace American Insurance Company

MFDR Tracking Number

M4-26-0504-01

Insurance Carrier's Austin Representative

BOX 15 Downs Stanford PC

DWC Date Received

October 22, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
April 24, 2025	Unspecified	\$422.98	\$422.98
May 22, 2025	Unspecified	\$422.98	\$422.98
June 20, 2025	Unspecified	\$422.98	\$422.98
July 21, 2025	Unspecified	\$422.98	\$422.98
August 18, 2025	Unspecified	\$422.98	\$422.98
Total		\$2,114.90	\$2,114.90

Requester's Position

Trustrx has previously dispensed and billed for the **same medication, Ciprofloxacin, on earlier** dates under this claim without any prior authorization requirement, and those claims were **processed and paid** by the carrier without issue."

Amount In Dispute: \$2,114.90

Respondent's Position

The Austin carrier representative for Ace American Insurance Co is Downs Stanford. The representative was notified of this medical fee dispute on October 24, 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 Section [413.031](#) and other applicable laws and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section [133.307](#) sets out the procedures for resolving medical fee disputes.
2. 28 TAC Section [134.503](#) sets out the fee guidelines for services provided by a pharmacy.
3. 28 TAC §§[134.530](#) and [134.540](#) set out the preauthorization requirements for pharmaceutical services.

Adjustment Reasons

- 197 – Precertification/authorization/notification absent.
- Payment denied – Unauthorized provider or facility
- 18 – Duplicate claim/service.

Issues

1. What is DWC considering in this medical fee dispute?
2. Is prior authorization required for disputed service?
3. Is the requester entitled to reimbursement?

Findings

1. The requester is seeking reimbursement for the medication Ciprofloxacin for dates of service from April 2025 through August 2025. The insurance carrier denied for lack of prior authorization. The amount in dispute is \$2,114.90.
2. 28 TAC Section 134.530 (b)(1)(A) is the rule applicable to prior authorization of pharmacy services and states, Preauthorization is only required for drugs identified with a status on

“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 the medication Ciprofloxacin is listed as a “Y” drug. The insurance carrier’s denial is not supported.

- The service in dispute will be reviewed per the applicable fee guidelines. 28 TAC Section 134.503(c)(1)(A)(B) 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;

Brand-name drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 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
Ciprofloxacin	59651086701	G	5.58/60	\$422.98	\$422.98	\$422.98

- The DWC finds that the requester is entitled to reimbursement in the amount of \$422.98 for the dates of service in dispute. The total due to the requester is \$2,114.90.

Conclusion

The outcome of this medical fee dispute is based on the evidence requester and the respondent presented at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that reimbursement is due.

Order

Under Texas Labor Code Sections [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 \$2,114.90 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section [134.130](#).

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

January 20, 2026

Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC Section [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 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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section [141.1\(d\)](#).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electrónico CompConnection@tdi.texas.gov.