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

AIU Insurance Co

MFDR Tracking Number

M4-26-1714-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

February 18, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
February 7, 2025	Cyclobenzaprine NDC 16571-0783-50	$65.52	$0.00
February 7, 2025	Meloxicam NDC 29300-0125-10	$185.69	$0.00
	Total	$251.21	$0.00

Requester's Position

"Both medications are refills of prescriptions that were accepted and paid in full by the carrier, thereby establishing compensability and medical necessity under the claim."

Amount In Dispute: $251.21

Respondent's Position

The Austin carrier representative for AIU Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on February 19, 2026.

Per 28 Texas Administrative Code §133.307(d)(1), if DWC does not receive the response within 14 calendar days of the dispute notification, then 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.

Adjustment Reasons

The insurance carrier denied payment for the disputed services with the following reasons:

- B13, HE83, - Duplicate Paid/Captured Claim
- 29 – This bill was submitted after the billing timeliness guidelines provided.
- P12 – The provider or a different provider has billed for the exact service on a previous bill where no allowance was originally recommended.
- HE75 – Prior authorization required to process this bill.

Issues

1. What is DWC considering in this medical fee dispute?
2. Has the requester waived their right to MFDR?

Findings

1. The requester seeks reimbursement for the medications Cyclobenzaprine and Meloxicam dispensed on February 7, 2025. The insurance carrier denied the charges and issued payment in the amount of $0.00. Accordingly, the requester seeks reimbursement totaling $251.21. The division must determine whether the requester is entitled to reimbursement for the disputed services.
2. The requirements for filing a medical fee dispute resolution (MFDR) request are set forth in 28 TAC Section 133.307(c)(1). Under this rule, a requester must file an MFDR request with the Division within one year of the date of service in dispute or waive the right to MFDR. A request is considered filed on the date it is received by the Division.

The rule provides limited exceptions permitting filing beyond the one-year deadline:

(A) request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

(B) A request may be filed later than one year after the date(s) of service if:

(i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requester receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability;

(ii) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requester received the final decision on medical necessity, inclusive of all appeals, related to health care in dispute and for which the insurance carrier previously denied payment based on medical necessity; or

(iii) the dispute relates to a refund notice issued pursuant to a division audit or review; the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice.

The Division concludes that the disputed date of service is February 7, 2025. The request for medical fee dispute resolution was received by the Division on February 18, 2026, after the one-year filing deadline. The requester did not establish that any exception to the filing deadline applies and, therefore, waived the right to pursue medical fee dispute resolution for the disputed services.

Conclusion

The outcome of this medical fee dispute is based on the evidence the 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 not established that reimbursement is due.

Order

Under Texas Labor Code Sections 413.031 and 413.019, DWC has determined the requester is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 13, 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 electronico CompConnection@tdi.texas.gov.