TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

TrustRX Pharmacy

Respondent Name

American Home Assuranc Company

MFDR Tracking Number

M4-26-1977-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

March 16, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
August 27, 2025	Methocarbam – NDC 70010-0754-01	$61.14	$61.14
	Total	$61.14	$61.14

Requester's Position

"TrustRX originally submitted the above bill electronically on 08/29/2025 to PayerID WX867 in compliance with Division electronic billing requirements. The bill was initially denied for diagnosis code, which TrustRx asserts is an incorrect denial because pharmacies do not submit diagnosis codes as part of the standard pharmacy billing."

Amount In Dispute: $61.14

Respondent's Position

The Austin carrier representative for American Home Assurance Company is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on April 1, 2026.

Per 28 Texas Administrative Code Section 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.
2. 28 TAC Section 133.20 sets out the requirements for medical bill submission.
3. 28 TAC Section 134.503 sets out the fee guidelines for services provided by a pharmacy.

Adjustment Reasons

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

- HE01 – Denial – the diagnosis code(s) on this bill are not covered.
- 60(B13) – The provider has billed for the exact services on a previous bill.
- XD(29) – This bill was submitted after the billing timeliness guidelines provided.
- ER(P12) – The provider or a different provider has billed for the exact service on a previous bill where no allowance was originally recommended.

Issues

1. What is DWC considering in this medical fee dispute?
2. Is the insurance carrier's denial supported?
3. What rule is applicable to reimbursement?

Findings

1. The requester is seeking reimbursement of the medication Methocarbam on date of service August 27, 2025 in the amount of $61.14. The insurance carrier denied the payment based on diagnosis, timeliness and duplicate bill. DWC will review the information submitted based on DWC rules and fee guidelines.

2. The requirements of pharmacy bill submission is found in 28 TAC 133.10(f)(3)(A) – (AA). The requirement of a diagnosis code is not one of the required elements. The carrier's original denial is not supported. The insurance carrier did not support the denials of timeliness or duplicate bill. These will not be considered in this review.

3. 28 TAC Section 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 per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

   (B) Brand-name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;

Drug Name	NDC	(g)eneric name (b)rand name	AWP/units	Billed amount	Lesser of billed amount or AWP
Methocarbam	70010075401	G	0.507/90	$61.14	$61.14

   Based on the information presented for this dispute, DWC finds the requester is due $61.14 for the medication Methocarbam for date of service August 27, 2025.

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 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 American Home Assurance Company must remit to TrustRx $61.14 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	June 17, 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.