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

Requestor Name
Injured Workers Pharmacy

Respondent Name
AIU Insurance Co.

MFDR Tracking Number
M4-25-0128-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 17, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 5, 2024	70512010610	$917.39	$914.39

Requestor's Position

"The insurance carrier has not provided any EOBs pertaining to this bill and attempt to reach the adjuster have been unanswered."

Amount in Dispute: $917.39

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 September 24, 2024.

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 (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) §133.240 sets out the procedures for payment or denial of a medical bill.

2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

3. 28 TAC §134.503 sets out the fee guidelines for pharmaceutical services.

Denial Reasons

Neither party submitted an explanation of benefits with reasons for the denial of payment for the disputed services.

Issues

1. Did AIU Insurance Co. take final action on the bill for the disputed service before medical fee dispute resolution was requested?

2. Is Injured Workers Pharmacy entitled to reimbursement for the drugs in question?

Findings

1. Injured Workers Pharmacy is seeking reimbursement for Diclofenac Sodium 1% Gel dispensed on January 5, 2024. The requestor argued that it did not receive payment or an explanation of benefits for medical bills submitted for the drug in question.

   Per 28 TAC §133.240(a), the insurance carrier is required to take final action by paying, reducing, or denying the service in question not later than 45 days after receiving the medical bill. This deadline is not extended by a request for additional information.

   The greater weight of evidence presented to DWC supports that a complete bill for the services in question was submitted to the insurance carrier or its agent. No evidence was provided to support that the insurance carrier took final action on the bill for the service in question.

2. Because the insurance carrier failed to provide any defenses for its non-payment of the drug in question, DWC finds that Injured Workers Pharmacy is entitled to reimbursement.

   The reimbursement considered in this dispute is calculated according to 28 TAC §134.503(c)(1)(A), with relevant formula for generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount.

Diclofenac Sodium 1% Gel (NDC 70512010610): (2.4277 x 300 x 1.25) + $4.00 = $914.39

The total allowable reimbursement is $914.39. This amount is recommended.

Conclusion

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

DWC finds the requestor has established that reimbursement of $914.39 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that AIU Insurance Co. must remit to Injured Workers Pharmacy $914.39 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	May 7, 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. 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 electronico CompConnection@tdi.texas.gov.