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
American Casualty Co. of Reading PA

MFDR Tracking Number
M4-25-0619-01

Carrier's Austin Representative
Box Number 57

DWC Date Received
November 13, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 1, 2024	70512010610	$610.73	$610.73

Requestor's Position

"The insurance carrier has denied the medication for no pre-authorization/pre-certification. The medication is a 'Y' status drug per the Texas formulary, so would not require approval prior to filling. We sent an appeal explaining this, but the medication continues to deny for the same reason of no-preauthorization/certification."

Amount in Dispute: $610.73

Respondent's Position

"Regarding multiple CPT codes which were billed for date of service 05/01/2024, Carrier has forwarded this to our bill review vendor, Conduent, to be reaudited. To date, Carrier has not received a response from the URA regarding this matter. At this time, Carrier maintains any and all denials as represented in the attached EORs."

Response Submitted by: Law Office of Brian J. Judis

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) §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.503 effective October 23, 2011, 36 TexReg 6949 sets out the fee guidelines for pharmaceutical services prior to November 28, 2024.

3. 28 Texas Administrative Codes §§134.530 and 134.540 effective January 17, 2011, 35 TexReg 11344 set out the closed formulary requirements for pharmaceutical services prior to November 28, 2024.

Denial Reasons

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

- 197 – Payment denied/reduced for absence of precertification/authorization.
- 5026 – First Script has denied the line for utilization.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Is the insurance carrier's denial based on preauthorization supported?

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

Findings

1. Injured Workers Pharmacy is seeking reimbursement for Diclofenac Sodium dispensed on May 1, 2024. The insurance carrier denied payment for lack of preauthorization.

   Per 28 TAC §134.530(b)(1) and §134.540(b), preauthorization is only required for:

   - drugs identified with a status of "N" in the current edition of the ODG Appendix A;
   - any compound prescribed before July 1, 2018, that contains a drug identified with a status of "N" in the current edition of the ODG Appendix A;
   - any prescription drug created through compounding prescribed and dispensed on or

after July 1, 2018; and
- any investigational or experimental drug.

DWC finds that Diclofenac Sodium is not identified with a status of "N" in the applicable edition of the ODG, *Appendix A*. Therefore, this drug does not require preauthorization for this reason.

The submitted documentation does not support that the disputed drug is a compound. Therefore, this drug does not require preauthorization for this reason.

The submitted documentation does not support that the disputed drug is experimental or investigational. Therefore, this drug does not require preauthorization for this reason.

DWC concludes that the insurance carrier's denial of payment of the disputed drug based on preauthorization is not supported.

2. Because the insurance carrier failed to support its denial of payment for 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: [(2.4277 x 200) x 1.25] + $4.00 = $610.93

   The total allowable reimbursement is $610.93. The requestor is seeking $610.73. 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 $610.73 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 American Casualty Co. of Reading PA must remit to Injured Workers Pharmacy $610.73 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.