



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Summit Pharmacy Inc

**Respondent Name**

Ace American Insurance Co

**MFDR Tracking Number**

M4-25-1000-01

**Carrier's Austin Representative**

Box Number 15

**DWC Date Received**

January 10, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 31, 2024		\$80.76	\$69.88
February 26, 2024		\$121.59	\$113.94
March 28, 2024		\$122.68	\$113.94
April 30, 2024		\$92.12	\$13.95
May 30, 2024		\$213.87	\$205.13
July 11, 2024		\$111.68	\$102.94
August 22, 2024		\$110.22	\$102.94
		<b>\$853.92</b>	<b>\$722.72</b>

### Requestor's Position

"Attached to this Medical Fee Dispute Resolution request are the following: Copy of the original Bill(s) sent to carrier, copy of original denials, copy of appeals that were sent to the carrier (regarding original denial), copy of denials after appeals were processed..."

**Amount in Dispute:** \$853.92

## **Respondents' Position**

The Austin carrier representative for Ace American Insurance Co is Downs Stanford PC. The representative was notified of this medical fee dispute on January 14, 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 §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

### Statutes and Rules

1. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §133.10](#) sets out the required elements of medical bills.
3. [28 TAC §134.503](#) sets out the fee guidelines for pharmacy services.

### Denial Reasons

- 146 – Diagnosis was invalid for the date(s) of service reported.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 18 – Duplicate claim/service.
- W -12 Charge unrelated to the compensable injury.
- 219 – Based on extent of injury.
- W11 – Entitlement of benefits

### Issues

1. Are the insurance carrier's denials supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to reimbursement?

### **Findings**

1. The requestor seeks reimbursement pharmacy services rendered from January 31, 2024, through August 22, 2024. The insurance carrier denied the services for multiple reasons. These denials are addressed as follows.

Diagnosis was invalid for the date(s) of service reported. DWC Rule 133.10 (f)(3)(A) – (AA) sets out the requirements of pharmacy bill (DWC 66). A diagnosis code is not one of the required elements. Insufficient evidence was found to support how the invalid diagnosis found on the explanation of benefits resulted as the submitted DWC66 submitted with the request for MFDR did not require/contain a diagnosis code.

A denial for the extent of injury was also used in the adjudication of these services. DWC Rule 28 TAC §133.307(d)(2)(H) requires that if the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with Rule §124.2 (relating to carrier reporting and notification requirements).

28 TAC §124.2(h) requires notification to the division and claimant of any dispute of disability or extent of injury using plain language notices with language and content prescribed by the division. Such notices “shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim.”

Review of the submitted information finds no copies, as required by Rule §133.307(d)(2)(H), of any PLN-11 or PLN 1 notices issued in accordance with Rule §124.2. The insurance carrier's denial reason is therefore not supported. Furthermore, because the respondent failed to meet the requirements of Rule §133.307(d)(2)(H) regarding notice of issues of extent of injury, the respondent has waived the right to raise such issues during dispute resolution. Consequently, the division concludes there are no outstanding issues of compensability, extent, or liability for the injury. The disputed services are therefore reviewed pursuant to the applicable rules and guidelines.

2. DWC Rule 28 Texas Administrative Code §134.503 (c)(1)(A)(B) states in pertinent part (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

(1) 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:

(A) Generic drugs:  $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \$4.00$  dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs:  $((\text{AWP per unit}) \times (\text{number of units}) \times 1.09) + \$4.00$  dispensing fee per prescription = reimbursement amount;

Date of Service	Drug	NDC	Generic(G) Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
1/31/2024	Acetaminophen	70010016001	G	0.09	60	\$11.01	\$14.25	\$11.01
1/31/2024	Biofreeze Gel	59316010212	G	0.10	89	\$13.95	\$21.59	\$13.95
1/31/2024	Cyclobenzaprine	29300041510	G	1.09	30	\$44.93	\$44.92	\$44.92
2/26/2024	Acetaminophen	70010016001	G	0.09	60	\$11.01	\$11.00	\$11.00
2/26/2024	Apap/Codeine	00406048410	G	1.03	15	\$23.47	\$23.48	\$23.47
2/26/2024	Biofreeze Gel	59316010212	G	0.10	89	\$13.95	\$21.59	\$13.95
2/26/2024	Cyclobenzaprine	16571078310	G	1.64	30	\$65.52	\$65.52	\$65.52
3/28/2024	Acetaminophen	70010016001	G	0.09	60	\$11.01	\$11.00	\$11.00
3/28/2024	Apap/Codeine	00406048410	G	1.03	15	\$23.47	\$30.75	\$23.47
3/28/2024	Biofreeze Gel	59316010212	G	0.10	89	\$13.95	\$15.41	\$13.95
3/28/2024	Cyclobenzaprine	16571078310	G	1.64	30	\$65.52	\$65.52	\$65.52
4/30/2024	Biofreeze Gel	59316010212	G	0.10	89	\$13.95	\$15.41	\$13.95
5/30/2024	Apap/Codeine	00406048410	G	1.03	15	\$23.47	\$30.75	\$23.47
5/30/2024	Cyclobenzaprine	16571078310	G	1.64	30	\$65.52	\$65.52	\$65.52
5/30/2024	Biofreeze	59316010212	G	0.10	89	\$13.95	\$15.41	\$13.95
5/30/2024	Paroxetine	13107015430	G	2.618	30	\$102.19	\$102.19	\$102.19
7/11/2024	Cyclobenzaprine	16571078310	G	1.64	30	\$65.52	\$65.52	\$65.52
7/11/2024	Biofreeze Gel	59316010212	G	0.10	89	\$13.95	\$15.41	\$13.95
7/11/2024	Apap/Codeine	00406048410	G	1.03	15	\$23.47	\$30.75	\$23.47
8/22/2024	Apap/Codeine	00406048410	G	1.03	15	\$23.47	\$30.75	\$23.47
8/22/2024	Biofreeze Gel	59316010212	G	0.10	89	\$13.95	\$13.95	\$13.95
8/22/2024	Cyclobenzaprine	16571078310	G	1.64	30	\$65.52	\$65.52	\$65.52

3. The documents reviewed during MFDR did not contain a submitted medical claim for date of service April 30, 2024 for the medication Cyclobenzaprine and Acetaminophen. DWC Rule 133.307 (c)(2)(J) states in relevant parts, "The request must include: a copy of all medical bills related to the dispute..." As no copy of the medical bill for these two medications was found no payment is recommended.

The total reimbursement calculation is based on the MAR for the medications listed above, shown in the "Summary of Findings" above, totaled by the date of service. The recommended payment amount is \$722.72.

### 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 requester has established that additional reimbursement 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 Ace American Insurance Co must remit to Summit Pharmacy Inc \$722.72 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

\_\_\_\_\_  
April 9, 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](http://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 3 or email [CompConnection@tdi.texas.gov](mailto: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 3 o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).