



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Injured Workers Pharmacy LLC

**Respondent Name**

Pie Insurance Company

**MFDR Tracking Number**

M4-25-1470-01

**Carrier's Austin Representative**

Rep Box 19

**DWC Date Received**

March 4, 2025

### Summary of Findings

| Dates of Service | Disputed Services                            | Amount in Dispute          | Amount Due |
|------------------|--|----------------------------|------------|
| March 22, 2024   | NDC # 70512010610 / Diclofenac Sodium Gel 1% | \$307.46                   | \$307.46   |
| March 22, 2024   | NDC # 52817033050 / Cyclobenzaprine          | \$127.04                   | \$127.04   |
| March 25, 2024   | NDC # 58468009003 / Synvisc One Injection    | \$1,795.46                 | \$1,795.46 |
| May 28, 2024     | NDC # 59651036205 / Ibuprofen                | \$55.38                    | \$55.38    |
| May 28, 2024     | NDC # 52817033050 / Cyclobenzaprine          | \$127.04                   | \$127.04   |
| May 28, 2024     | NDC # 70512010610 / Diclofenac Sodium Gel 1% | \$307.46                   | \$307.46   |
| <b>Total</b>     |  | \$2,846.88<br>(\$2,719.84) | \$2,719.84 |

### Requestor's Position

"ALLIANZ GLOBAL CORPORATE has denied the attached bills due to lack of prior authorization along with other denials which are also invalid. The medications are authorized, and we know this based on our payment history. The medications we filled are 'Y' status drugs on the ODG and does not require prior authorization. We sent multiple appeals stating our case and the denial remained."

**Amount in Dispute:** \$2,846.88 (\$2,719.84)

## **Respondent's Position**

The Austin carrier representative for Pie Insurance Company is Flahive Ogden & Latson. Flahive Ogden & Latson was notified of this medical fee dispute on March 12, 2025. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

## **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 Texas Administrative Code ([TAC](#)) [§133.305](#) sets out the general procedures for medical dispute resolution.
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 pharmacy.
4. 28 TAC §§[134.530](#) and [134.540](#) effective April 22, 2018, 43 TexReg 2275 set out the preauthorization requirements for pharmaceutical services before November 28, 2024.

### **Denial Reasons**

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

- 18 - Exact duplicate claim/service.
- 193 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 224 - Duplicate charge.
- 251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim.
- 350 - Bill has been identified as a request for reconsideration or appeal.
- 91 - Dispensing fee adjustment.
- 95 - Plan procedures not followed.
- G01 - This item was priced as a generic prescribed drug.
- G09 - This item was priced as a brand-name prescribed drug.
- G10 - This service was priced at submitted charges.

- P12 – Workers’ compensation jurisdictional fee schedule adjustment.
- Q02 - No additional allowance recommended. The documentation has been evaluated and does not support an additional allowance.
- Q08 – Detailed NDC-J code, dosage and strength must be provided for this drug (or all components of a compound drug).
- U00 - There was no UR procedure/treatment request received.
- W3 - In accordance with TDI-DWC RULE 134.804, this bill has been identified as a request for reconsideration or appeal.
- Notes: Re-evaluation: No additional allowance recommended, this has been re-evaluated and does not support any additional allowance. Detailed NDC - J Code, dosage and strength must be provided for this drug (Please submit all components of a compound drug). We cannot add additional lines to reconsiderations. Resubmit for DOS 06-24/2024. Re-evaluation Review is only for resubmitted bill DOS 0/10/2024,03/22/2024.

### **Issues**

1. Did the insurance carrier support the denial reason code U00?
2. Is insurance carrier’s denial reason(s) supported?
3. Is the requester entitled to additional reimbursement?

### **Findings**

1. The insurance carrier denied the disputed medications with claim adjustment reason code “U00 - There was no UR procedure/treatment request received.”

Review of the Appendix A, ODG Workers’ Compensation Drug Formulary finds the following:

- Generic brand / 70512010610 / Diclofenac Sodium Gel 1%
- Generic brand / 52817033050 / Cyclobenzaprine
- Name brand / 58468009003 / Synvisc One Injection
- Generic brand / 59651036205 / Ibuprofen
- Generic brand / 52817033050 / Cyclobenzaprine
- Generic brand / 70512010610 / Diclofenac Sodium Gel 1%

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 investigation or experimental drug.

DWC finds that the drugs in question are not identified with a status of “N” in the applicable edition of the ODG, *Appendix A*. Therefore, the drugs do not require preauthorization for this reason.

The submitted documentation does not identify the disputed drugs as a compound. Therefore, these drugs do not require preauthorization for this reason.

The submitted documentation does not identify the disputed drugs as experimental or investigational. Therefore, these drugs do 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. 28 TAC §134.503 (c) states 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:
  - Generic drugs:  $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \$4.00$  dispensing fee per prescription = reimbursement amount;

| Date    | Drug                        | NDC         | Generic(G)<br>Brand(B) | Price /<br>Unit | Units<br>Billed | AWP<br>Formula | Billed Amt | Lesser of<br>AWP<br>and Billed<br>Amt |
|---------|-----------------------------|-------------|------------------------|-----------------|-----------------|----------------|------------|---------------------------------------|
| 3/22/24 | Diclofenac<br>Sodium Gel 1% | 70512010610 | G                      | 2.4277          | 100             | \$307.46       | \$307.46   | \$307.46                              |
| 3/22/24 | Cyclobenzaprine             | 52817033050 | G                      | 1.6405          | 60              | \$127.04       | \$127.04   | \$127.04                              |
| 3/25/24 | Synvisc One<br>Injection    | 58468009003 | B                      | 273.92          | 6               | \$1,795.46     | \$1,795.46 | \$1,795.46                            |
| 5/28/24 | Ibuprofen                   | 59651036205 | G                      | 0.685           | 60              | \$55.38        | \$55.38    | \$55.38                               |
| 5/28/24 | Cyclobenzaprine             | 52817033050 | G                      | 1.6405          | 60              | \$127.04       | \$127.04   | \$127.04                              |
| 5/28/24 | Diclofenac<br>Sodium Gel 1% | 70512010610 | G                      | 2.4277          | 100             | \$307.46       | \$307.46   | \$307.46                              |
| TOTAL   |                             |             |                        |                 |                 | \$2,719.84     | \$2,719.84 | \$2,719.84                            |

The total reimbursement is \$2,719.84. 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 requester has established that reimbursement of \$2,719.84 is due.

## Order

Pursuant to the 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 the respondent must remit to the requestor \$2,719.84 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

### Authorized Signature

|           |  |              |
|-----------|--|--------------|
| _____     | _____                                  | June 6, 2025 |
| Signature | Medical Fee Dispute Resolution Officer | 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, 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).