



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Injured Workers Pharmacy

**Respondent Name**

State Office of Risk Management

**MFDR Tracking Number**

M4-25-1793-01

**Carrier's Austin Representative**

Box Number 45

**DWC Date Received**

April 3, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 12, 2024	NDC # 70512010610 Diclofenac Sodium Gel 1%	\$307.46	\$307.46

### Requestor's Position

"A Medical Fee Dispute Resolution request has been submitted for invoices not paid for by The State office of Risk Management. The carrier denied the date of service 4/12/24 DICLOFENAC SODIUM 1% GEL. The denial was for no medical records. Our pharmacy secured the medicals from the provider and sent them to the carrier following the appeal protocol. The medicals called out the specific treatment of the medication for ..., which from my understanding is compensable. However, our appeal was denied for the same reason (no medicals)."

**Amount in Dispute:** \$307.46

### Respondent's Position

"In a review of the medications in dispute, the Office will maintain its denial at this time. There is no medical evidence submitted from the prescribing doctor supporting that these medications are for the treatment of the compensable injury as noted above. The medical shows no acute findings on the diagnostics and medical exam, further indicating the chief complaint of ...."

**Response Submitted by:** State Office of Risk Management

## 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 procedures for resolving medical disputes.
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.

### Denial Reasons

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

- 16 – Claim/service lacks information which is needed for adjudication. Remark codes whenever appropriate.
- Note: There is no medical to support the rationale for the use of this medication.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
- W3 – Reporting purposes only.
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- Note: No updated medical to support the rationale of this medication to treat the compensable injury.

### Issues

1. Did the insurance carrier submit a copy of a PLN in support of the denial reason?
2. Is the requester entitled to additional reimbursement?

### Findings

1. The requestor is seeking reimbursement for the prescription for Diclofenac Sodium Gel 1% dispensed on April 12, 2024. The medication in dispute was denied by the workers' compensation carrier due to an unresolved extent of injury issue.

28 TAC §133.307(d)(2)(H), "Responses. Responses to a request for MFDR must be legible and submitted to the division and to the requestor in the form and manner prescribed by the division... (H) If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier must attach any related Plain Language Notice in accordance with §124.2 of this title (concerning Insurance Carrier Reporting and Notification Requirements)."

Review of the documentation submitted by the parties, finds that the carrier did not provide documentation to the Division to support that it filed a Plain Language Notice (PLN) regarding the disputed conditions as required by §133.307(d)(2)(H).

The respondent did not submit information to MFDR, sufficient to support that the PLN had ever been presented to the requestor or that the requestor had otherwise been informed of PLN prior to the date that the request for medical fee dispute resolution was filed with the DWC; therefore, the DWC finds that the compensability denial was not timely presented to the requestor. Because the service in dispute does not contain an unresolved extent of injury issue, this matter is eligible for adjudication of a medical fee under 28 TAC §133.307. For that reason, this matter is addressed pursuant to the applicable rules and guidelines.

2. The requestor is seeking payment for the prescription Diclofenac Sodium Gel 1% provided on April 12, 2024. Because the insurance carrier’s denial reasons are not supported, the requestor is entitled to reimbursement pursuant to 28 TAC 134.503.

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

Drug	NDC	Generic(G) Brand(B)	Price / Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed Amt
Diclofenac Sodium Gel 1%	70512010610	G	2.42770	100	\$307.46	\$307.46	\$307.46
<b>TOTAL</b>					\$307.46	\$307.46	\$307.46

The total reimbursement is \$307.46. 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 is entitled to reimbursement in the amount of \$307.46.

## 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 the respondent must remit to the requestor \$307.46 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

### Authorized Signature

_____	_____	April 16, 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).