TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
INJURED WORKERS PHARMACY LLC

Respondent Name
TEXAS MUNICIPAL LEAGUE INTERGOVERNMENTAL RISK

MFDR Tracking Number
M4-20-1746-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 13, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Diclofenac Sodium 3% gel is not N drug and therefore does not require preauthorization … As there does not appear to be any substantiation to TML Insurance's denial, with respect to preauthorization requirements and provider eligibility, we request that TML Insurance pay the outstanding invoices in full."

Amount in Dispute: $5,905.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Self-Insured considers the prescribed medication, in combination with the gel medium used, a compound drug requiring preauthorization."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 5 and 29, 2019	Diclofenac Sodium 3% Gel	$5,905.30	$5,905.30

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
3. 28 Texas Administrative Codes §§134.530 and 134.540 set out the preauthorization requirements for pharmaceutical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 171 – The rendering provider is not eligible to perform the service billed.

- 197 – Precertification/authorization/notification absent.
- 240 – Preauthorization not obtained.

Issues

1. Is the insurance carrier's denial of payment based on provider eligibility supported?
2. Is the insurance carrier's denial of payment based on preauthorization supported?
3. Is the requestor entitled to reimbursement for the drug in question?

Findings

1. Injured Workers Pharmacy LLC is seeking reimbursement for Diclofenac Sodium 3% gel dispensed on June 5, 2019, and June 29, 2019. The insurance carrier denied the disputed drug, in part, stating that "The rendering provider is not eligible to perform the service billed."

   No evidence was provided to support that Injured Workers Pharmacy LLC was not eligible to dispense the drug in question. The DWC finds that this denial reason is not supported.

2. The insurance carrier also denied the drug in question based on preauthorization. Preauthorization is only required for:

   - drugs identified with a status of "N" in the current edition of the ODG Appendix A[1];
   - any prescription drug created through compounding prescribed before July 1, 2018 that contains a drug identified with a status of "N" in the current edition of the ODG Appendix A, and any updates;
   - any prescription drug created through compounding prescribed and dispensed on or after July 1, 2018; and
   - any investigational or experimental drug.[2]

   The DWC finds that the evidence presented by Injured Workers Pharmacy LLC supports that the drug in this dispute is not identified with a status of "N" in the current edition of the ODG Appendix A.

   Flahive, Ogden & Latson, on behalf of the insurance carrier, argued in its position statement that the drug is a compound. No evidence was presented to support that Diclofenac Sodium 3% gel, NDC 68462035594, is a compounded drug.

   No evidence was presented to support that the drug in question was investigational or experimental. The insurance carrier's preauthorization denial is therefore not supported.

3. Because the insurance carrier failed to support its denial reasons for the drug in this dispute, the DWC finds that Injured Workers Pharmacy LLC is entitled to reimbursement.

   The reimbursement considered in this dispute is calculated as follows[3]:

   - Diclofenac Sodium 3% gel: (11.79460 x 200 x 1.25) + $4.00 = $2,952.65

   The total allowable reimbursement is $5,905.30 for two dates of service. This amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $5,905.30.

[1] *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary*
[2] 28 Texas Administrative Codes §§134.530 (b)(1) and 134.540 (b)
[3] 28 TAC §134.503 (c)

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor $5,905.30, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		April 17, 2020
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 in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.