TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding RX

Respondent Name
Accident Fund General Insurance Co

MFDR Tracking Number
M4-20-2966-01

Carrier's Austin Representative
Box Number 6

MFDR Date Received
August 19, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was denied for pre-authorization."

Amount in Dispute: $815.97

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Austin carrier representative for Accident Fund General Insurance Co is Stone Loughlin & Swanson LLP who was notified of this medical fee dispute on August 25, 2020. 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).

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 27, 2020	Oral medication	$815.97	$0.00

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.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.530 sets out prior authorization for pharmacy services.
3. The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:
   - 293 – This procedure requires prior authorization and none was identified

- 15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.

Issues

Is the insurance carrier's denial of payment supported?

Findings

The requestor is seeking reimbursement of oral medication Pregabalin. The insurance carrier denied the disputed service as service require prior authorization and none was submitted or requested.

28 TAC §134.530 (b)(1)(A) states in pertinent part, preauthorization is only required for drugs identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates.

Review of Appendix A found,

Drug Class	Generic Name	Brand Name	Gener Equiv	Status
Anti-epilepsy drugs (AEDs)	Pregabalin	Lyrica ® IR	No	Y
Anti-epilepsy drugs (AEDs)	Pregabalin	Lyrica® CR	No	N

Review of the information submitted by the requestor was "Pregabalin 50 mg capsule, NDC 50228-0351-90."

As shown above, Appendix A shows two forms of the medication. One requires prior authorization and one does not. The information provided was insufficient to support the requestors statement, "These medications do not require preauthorization…" No payment is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 29, 2020 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to 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 TAC §141.1(d).

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