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
MEMORIAL COMPOUNDING RX

Respondent Name
UNITED AIRLINES INC

MFDR Tracking Number
M4-21-0689-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
December 21, 2020

REQUESTOR'S POSITION SUMMARY

"These medications do not require preauthorization therefore do not need a retrospective review."

Amount in Dispute: $174.20

RESPONDENT'S POSITION SUMMARY

"Claimant's physician requested preauthorization of the medication in dispute. The request for preauthorization was denied. The Claimant then went to another doctor to prescribe the medication, and Requestor filled that medication. Reimbursement for the medication was denied based on the denial of preauthorization."

Response Submitted by: Downs-Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 14, 2020	Diclofenac Sodium 1% Gel	$174.20	$149.88

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 Code §134.503 sets out the requirements for pharmacy prior authorization.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - G01 – This item is reimbursed as a generic prescribed drug.
   - PS2 – NDC charge(s)have been denied and no payment is recommended per script advisor clinical and formulary-based review
   - 91 – Dispensing fee adjustment.

Issues

1. Is the insurance carrier's denial of payment supported?
2. Is Memorial Compounding Rx (Memorial) entitled to additional reimbursement?

Findings

1. Memorial is seeking reimbursement for Diclofenac Sodium Gel, dispensed on September 14, 2020. United Airlines, Inc. denied payment based on a denial of preauthorization and medical necessity.

   28 TAC 134.530 (b) states, in pertinent part, that 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 the relevant Appendix A found that the gel form of Diclofenac Sodium does not have a status of "N."

   Downs-Stanford, P.C. argued on behalf of the insurance carrier, that another doctor had requested preauthorization and had been denied. Because the drug in question does not require a preauthorization, it is considered a voluntary request.

   If the insurance carrier and the health care provider do not come to an agreement regarding the voluntary authorization of a service that does not require preauthorization, the service is subject to retrospective review of medical necessity.[1] The insurance carrier failed to provide any evidence that it performed a retrospective review of the medication in question. Therefore, the insurance carrier's denial of payment for this reason is not supported.

2. Because United Airlines, Inc. failed to support its denial reason for the service in this dispute, the DWC finds that Memorial is entitled to reimbursement.

   The reimbursement considered in this dispute is calculated as follows[2]:

   - Diclofenac Sodium 1% Gel: (0.5835 x 200 x 1.25) + $4.00 = $149.88

   The total allowable reimbursement is $149.88. 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 $149.88.

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 $149.88, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 10, 2021 Date

[1] 28 TAC §134.600 (r)
[2] 28 TAC §134.503 (c)

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.