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 Pharmacy

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-21-1267-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 24, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim should be processed with the full amount billed as per Administrative Labor Code 134.503."

Amount in Dispute: $115.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Austin carrier representative for New Hampshire Insurance Co is Flahive Ogden & Latson who was notified of this medical fee dispute on March 30, 2021. 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. This decision is based on the information available as authorized under §133.307(d)(1).

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 13, 2021	Diclofenac Sodium 1% Gel	$115.85	$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 the guidelines for prior authorization of pharmaceutical services.

Issues

What rule(s) apply to disputed services?

Findings

The requestor is seeking reimbursement for oral medication Diclofenac Sodium 1% Gel dispensed January 13, 2021.

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

Review of Appendix A found the following:

NSAIDs	Diclofenac sodium	Dyloject	No	N
NSAIDs	Diclofenac sodium	Voltaren ®	Yes	Y
NSAIDs	Diclofenac sodium topical	Pennsaid ®	Yes	N

Review of the submitted documentation found insufficient evidence to support the medication in dispute either did not require prior authorization and payment could be allowed or did require prior authorization and one was received to allow payment.

Based on this review no payment is recommended.

Conclusion

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement 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	June 17, 2021 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 division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division 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.