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 Pharmacy

Respondent Name
Star Indemnity & Liability Co

MFDR Tracking Number
M4-21-1437-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 14, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Texas Labor Code Section 408.027 (b) requires that the carrier must pay, reduce, deny or determine to audit the health provider's claim no later than the 45th day after the date of receipt by the carrier. Memorial did not receive any correspondence as per rule…"

Amount in Dispute: $174.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor billed for the medication NDC 21922-0009-09, diclofenac sodium topical gel, 1%. Appendix A, ODG Workers' Compensation Drug Formulary shows "diclofenac sodium topical" is an "N" drug. Therefore, per DWC Rule 134.530(b)(1)(A), this medication requires preauthorization. Respondent denied the medication due to the absence of preauthorization`."

Response Submitted by: Downs Stanford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 28, 2020	Diclofenac Sodium 1% Gel	$174.20	$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 requirements of prior authorization for pharmacy services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization

Issues

Is the insurance carrier's denial of payment supported?

Findings

The requestor is seeking reimbursement of prescribed medication dispensed on December 28, 2020. The insurance carrier denied the disputed service based on lack of prior authorization.

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

Review of Appendix A for this time-period found a "N" listing for the medication in dispute. No prior authorization was referenced and the requestor did not submit documentation to support this medication did not require prior authorization. The insurance carriers' denial is supported 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	May 13, 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 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.