TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Memorial Compounding RX

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-22-1134-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
February 10, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 15, 2021	21922-0009-09	$115.85	$0.00
	Total	$115.85	$0.00

Requestor's Position

"There were not any additional code charges or services rendered. Therefore, the carrier cannot change from the original denial."

Amount in Dispute: $115.85

Respondent's Position

The Austin carrier representative for Texas Mutual is Texas Mutual. The representative was notified of this medical fee dispute on February 16, 2022.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §137.100 sets out provision of the treatment guidelines.
3. 28 Texas Administrative Code §134.530 sets out the requirements of prior authorization of pharmacy services.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 762 – Treatment/service in excess ODG/DWC treatment guidelines in accordance with TAC Rule 134.502, 503 & 134.600(P)(12)
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Are the insurance carrier's reasons for denial supported?
2. Did the requestor support dispensed medication did not require prior authorization?

Findings

1. The requestor is seeking reimbursement of $115.85 for pharmacy services rendered in November 2021. The insurance denied the service stating treatment exceeded ODG/treatment guidelines.

   DWC Rule 28 Texas Administrative Code §137.100 (e) states,

   An insurance carrier may retrospectively review, and if appropriate, deny payment for

treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017.

DWC 28 Texas Administrative Code Part 1, Chapter 19, Subchapter U sets out the requirements for utilization review of health care provided under Texas workers' compensation insurance coverage.

Applicable 28 TAC §19.2003 (b)(31) defines retrospective review as "A form of utilization review for health care services that have been provided to an injured employee."

No documentation found to support that the insurance carrier retrospectively reviewed the reasonableness and medical necessity of the service in dispute pursuant to the minimal requirements of Chapter 19, subchapter U as required.

28 Texas Administrative Code 134.600 (p)(12) states, non-emergency health care requiring preauthorization includes treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier.

The carrier denied as treatment guidelines exceeded with meeting the requirements of retrospective review, the disputed service will be reviewed based on applicable DWC Rules.

2. DWC 28 Texas Administrative Code §134.530 (b)(1) states in pertinent part preauthorization is only require for drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A.

   Review of the applicable Appendix A found,

Drug Class	Generic Name	Brand Name	Gener Equiv	Status
NSAIDs	Diclofenac sodium	Dyloject	No	N
NSAIDs	Diclofenac sodium	Voltaren ®	Yes	Y

   Insufficient documentation was found to support the dispensed form of the medication was the brand name that did not require prior authorization. No payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not

entitled to additional reimbursement for the disputed services.

Authorized Signature

		May18, 2022
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

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

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.