TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Injured Workers Pharmacy

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-22-1471-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
March 18, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 26, 2021	Diclofenac Sodium 3% Gel 00115148361	$1,419.35	$1,419.35

Requestor's Position

The attached documentation comes directly from the ODG website. I used the EXACT NDC that we are shipping for the Diclofenac 3% (Voltaren), which is NDC 00115148361. The NDC is confirmed 3% (not 1%). We are NOT shipping the Voltaren XR, Pennsaid or Dyloject (these all require pre-authorization). The Voltaren Topical NDC 0011514836 does not require authorization prior to shipping.

Supplemental statement: Please note that the Official Disability Guidelines are recommendations and suggestions for providers to use. I am under the impression that an actual ODG review would have to be done to assess whether a medication would be approved or denied based on these guidelines. Please also note that the medication is in fact being prescribed for the lumbar region.

Amount in Dispute: $1,419.35

Respondent's Position

Audit staff reviewed the bill and determined that Official Disability Guidelines (ODG) does not recommend the use of Diclofenac 3% per review of the spine chapters … Additional review of the audit confirms an error with A11 denial reason code as Diclofenac does not require preauthorization, nor is it listed as an N drug. However, denial reason code also noted on the EOB 762 is applicable as it is not recommended for the spine region.

Response Submitted by: Texas Mutual Insurance Company

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 TAC §134.503 sets out the fee guidelines for pharmaceutical services.

3. 28 TAC §134.530 sets out the preauthorization requirements for pharmaceutical services not provided through certified health care networks.

Denial Reasons

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

- A11 – N Drug denial. Preauthorization required for "N" drugs in ODG Appendix A per rule 134.504.
- A21 – Clarification requested on drug, per ODG. This drug is listed as both N & Y status. Rx will be evaluated upon receipt of information.
- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-197 – Precertification/authorization/notification absent.
- 762 – Treatment/service in excess ODG/DWC treatment guidelines in accordance with TAC Rule 134.502, 503 & 134.600(p)(12)
- 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.
- Note: "892,A21,A11 = NDC listed is for diclofenac sodium gel 1%. Medication description is for diclofenac sodium gel 3%. Further clarification needed to determine which gel was dispensed to injured worker."
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 891 – No additional payment after reconsideration

Issues

1. Is Texas Mutual Insurance Company's denial of payment for the drug in question supported?

2. Is Injured Workers Pharmacy entitled to additional reimbursement?

Findings

1. Injured Workers Pharmacy is seeking reimbursement for Diclofenac Sodium 3% Gel dispensed on July 26, 2021.

   Texas Mutual Insurance Company denied the drug, in part, based on the NDC number, stating it was for Diclofenac Sodium 1% gel. In its position statement, the insurance carrier recognized the code as applying to Diclofenac Sodium 3% gel. This denial reason will not be reviewed.

   The insurance carrier also denied the drug, in part, based on preauthorization. In its position statement, it did not maintain this denial and acknowledged that preauthorization was not required. Therefore, this denial reason will not be reviewed.

   The insurance carrier also denied and maintained its denial stating that the drug was in excess of ODG/DWC treatment guidelines. The DWC rule found at 28 TAC §134.530 (d)(2), indicates that included in the division's closed formulary that exceed the division's adopted treatment guidelines may be prescribed and dispensed without preauthorization. DWC finds that this denial reason is not supported.

2. Because the insurance carrier failed to support its denial of payment for the drug in question, Injured Workers Pharmacy is entitled to reimbursement.

   The reimbursement considered in this dispute is calculated according to 28 TAC §134.503(c).

   - Diclofenac Sodium 3% Gel: (11.3228 x 100 x 1.25) + $4.00 = $1,419.35

   The total allowable reimbursement is $1,419.35. This amount 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 established that additional reimbursement of $1,419.35 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Texas Mutual Insurance Company must remit to Injured Workers Pharmacy $1,419.35 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 20, 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.