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
LEAGUE PHARMACY

Respondent Name
CITY OF HOUSTON

MFDR Tracking Number
M4-22-1845-01

Carrier's Austin Representative
Box Number 29

DWC Date Received
April 27, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 25, 2022	Lidocaine Pad 5%	$389.34	$0.00
March 25, 2022	Indomethacin 75 MG ER	$231.62	

Requestor's Position

Requestor did not provide a position statement.

Amount in Dispute: $620.96

Respondent's Position

"After further review of the additional information, the decision to stand on the original recommendation remains due to the lack of preauthorization for the prescription medication Lidocaine NDC – 65162079105. Perthe TDI website, Appendix A ODG drug formulary for the dae of service March 2022, this medication represents a N Drug requiring preauthorization."

Response Submitted by: IMO Managed Care

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.530 sets out the requirements of prior authorization for pharmacy services

Denial Reasons

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

- 197 – Precertification/authorization/notification absent

Issues

1. Was authorization of the disputed service required?

Findings

1. The requestor is seeking reimbursement for Lidocaine Patch and Indomethacin 75 MG dispensed on April 22, 2022. The insurance carrier denied the medications in dispute based on lack of prior authorization. 28 TAC §134.530 (b)(1) states Preauthorization is only required for: (A) 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 applicable Appendix A found

Drug Class	Generic Name	Brand Name	Gener Equiv	Status
Topical analgesics	Lidocaine	Lidoderm	Yes	**N**
NSAIDs	Indomethacin	Indocin	Yes	**N**
NSAIDs	Indomethacin	Tivorbex	No	**N**

   Requestor made no argument to support that the dispensed drug does not have a status of "N". No evidence of receipt of preauthorization for this drug was submitted to DWC.

   No reimbursement is due as DWC finds the dispensed medication in dispute includes status "N" in the revlevant edition of the ODG Appendeix A. Insurance carrier denial is supported therefore, reimbursement is due.

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

[redacted]	[redacted]	May 13, 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.