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
M4-22-1911-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
May 4, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 27, 2021	Diclofenac Sodium 3% Gel	$1,419.35	$1,419.35
December 20, 2021	Diclofenac Sodium 3% Gel	$1,419.35	$1,419.35
	Total	$2,838.70	$2,838.70

Requestor's Position

A Medical Fee Dispute Resolution request has been submitted for the medication DICLOFENAC SODIUM 3% GEL on date of service 10/27/21 and 12/20/21. The carrier denied the bill, stating the medication requires authorization prior to shipping. An appeal was submitted with proof that the medication DICLOFENAC SODIUM 3% GEL (NDC 0115148361) is a & status drug per the Texas Formulary, so it does not require authorization prior to shipping … However, the insurance carrier continues to deny the bills.

Amount in Dispute: $2,838.70

Respondent's Position

Texas Mutual Insurance Company was notified of this medical fee dispute on May 10, 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 TAC §134.503 sets out the fee guidelines for pharmaceutical services.

3. 28 TAC §§134.530 and 134.540 set out the preauthorization requirements for pharmaceutical services.

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 134.503 & 134.504.
- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-197 – Precertification/authorization/notification absent.
- 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.
- Notes: "A21-Medication listed on bill reflects a different % than the NDC# listed. Please clarify the discrepancy.
- A21 – Clarification requested on drug, per ODG, this drug is listed as both N & Y status. Rx will be evaluated upon receipt of information.
- 762 – Treatment/service in excess ODG/DWC treatment guidelines in accordance with TAC rule 134.502, 503 & 134.600(p)(12).
- 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 based on preauthorization supported?

2. Is Injured Workers Pharmacy entitled to reimbursement for the drug in question?

Findings

1. Injured Workers Pharmacy is seeking reimbursement for diclofenac sodium 3% gel dispensed on October 27, 2021, and December 20, 2021.

   Submitted documentation indicates that the insurance carrier denied the disputed drug based on preauthorization. Per 28 TAC §134.530(b)(1) and §134.540(b), preauthorization is only required for:

   - drugs identified with a status of "N" in the current edition of the ODG Appendix A;
   - any compound prescribed before July 1, 2018, that contains a drug identified with a status of "N" in the current edition of the ODG Appendix A;
   - any prescription drug created through compounding prescribed and dispensed on or after July 1, 2018; and
   - any investigational or experimental drug.

   DWC finds that diclofenac sodium **gel** is not identified with a status of "N" in the applicable editions of the ODG, *Appendix A*. Therefore, this drug does not require preauthorization for this reason.

   The submitted documentation does not support that the disputed drug is a compound. Therefore, this drug does not require preauthorization for this reason.

   The submitted documentation does not support that the disputed drug is experimental or investigational. Therefore, this drug does not require preauthorization for this reason.

   DWC concludes that the insurance carrier's denial of payment of the disputed drug based on preauthorization is not supported.

2. Because Texas Mutual Insurance Company failed to support its denial reason for the service in this dispute, DWC finds that 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 allowable reimbursement is $1,419.35 per date of service. The total allowable reimbursement in this dispute is $2,838.70. 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 $2,838.70 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 $2,838.70 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 1, 2022 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.