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
New Hampshire Insurance Co

MFDR Tracking Number
M4-22-2318-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
June 27, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 8, 2021	00115148361	$2,151.33	$0.00
September 2, 2021	45802011101	$211.98	$0.00
		$2,363.31	$0.00

Requestor's Position

"Injured Workers' Pharmacy (IWP) believes that these medications require pre-cert/auth. Injured Workers' Pharmacy (IWP) believes that these medications are ODG/Texas Formulary approved and do not require said pre-certification/authorization."

Amount in Dispute: $2,363.31

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed."

Response submitted by: Gallagher Bassett Services

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.
3. 28 TAC §19.2003 defines retrospective review.
4. DWC Rule 28 TAC §19.2015 sets out administrative process for utilization review.

Denial Reasons

- 197 – Payment denied/reduced for absence of precertification/authorization
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 5725 – First Script has denied the line for Utilization.

Issues

1. Did the carrier follow the appropriate administrative process to address the assertions made in its response to medical fee dispute?
2. Is the insurance carrier's denial supported?

Findings

1. The insurance carrier denied the payment of Diclofenac sodium. For utilization.

   Additionally, the respondent states prior authorization was not obtained as the ODG considers

   The division notes that 28 TAC §137.100 (e) sets out the appropriate administrative process for the carrier to retrospectively review reasonableness and medical necessity of care already provided.

   Section (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."

Retrospective review is defined in 28 TAC §19.2003 (28) as "The process of reviewing health care which has been provided to the injured employee under the Texas Workers' Compensation Act to determine if the health care was medically reasonable and necessary."

DWC Rule 28 TAC §19.2015(b) titled Retrospective Review of Medical Necessity states: (b) When retrospective review results in an adverse determination or denial of payment, the utilization review agent shall notify the health care providers of the opportunity to appeal the determination through the appeal process as outlined in Chapter 133, Subchapter D of this title (relating to Dispute and Audit of Bills by Insurance Carriers)."

The division finds that the carrier failed to follow the appropriate administrative process to address the denial of utilization. This denial will not be considered in this medical fee dispute.

2. The requestor is seeking reimbursement for oral medication dispensed in July 2021 and September 2021. The insurance carrier denied the disputed service based on lack of pre-authorization.

DWC Rule 134.530 (b) (1) (A) states in pertinent part, preauthorization is only required for 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 Appendix A found the for date of service July 8, 202, Diclofenac sodium is listed under two brand Names. Dyloject which is a "N" drug and Voltaren with is a "Y" drug.

Insufficient evidence such as a dispensing label was found in the documentation submitted with the request for MFDR to support which brand of medication was provided. The insurance carrier's denial is supported.

For date of service September 2, 2021, the Diclofenac sodium is listed in Appendix A by the brands Dyloject which is listed as a "N" drug and Voltaren which is listed as a "Y" drug.

Insufficient information was found to support which brand name drug was dispensed. The insurance carrier's denial is supported. No additional 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

Signature	Medical Fee Dispute Resolution Officer	September 13, 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.