Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Memorial Wellness Pharmacy

Respondent Name
XL Specialty Insurance Co

MFDR Tracking Number
M4-23-2446-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 25 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 14, 2022	21922-0009-09	$174.20	$149.88
		$174.20	$149.88

Requestor's Position

"The service billed has a "Y" code therefore does not require preauthorization."

Amount in Dispute: $174.20

Respondent's Position

"This bill is for diclofenac gel. Carrier has denied coverage for this topical drug for the use of this topical drug for the use in this compensable injury. According to the ODG, Diclofenac sodium topical gel, 1% is indicated for the relief of the pain of osteoarthritis of joints amenable to topical treatment, such as the knees and those of the hands. Diclofenac sodium topical gel, 1% has not been evaluated for use on the spine, hip or shoulder…"

Response submitted by: Flahive, Ogden & Latson

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 medical necessity denials.
3. 28 TAC §134.503 sets out the fee guidelines for pharmacy services.

Denial Reasons

- HE70 – Product/Service not covered

Issues

1. Did the carrier follow the appropriate administrative process to address the assertions made in its response to medical fee dispute?
2. What rule(s) apply to disputed services?
3. Is the requestor due reimbursement?

Findings

1. The insurance carrier denied the payment product/service not covered. 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 assertions made in its response to this medical fee dispute. The respondent's position statement is not supported.

2. The requestor is seeking reimbursement for medication dispensed in November 2022. The claim was denied as non covered. As stated above, the insurance carrier's denial was not in accordance with applicable DWC rule. The service in dispute will be reviewed per applicable fee guideline.

   DWC Rule 28 Texas Administrative Code §134.503 (c)(1)(A)(B) states in pertinent part (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

   (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:

   (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

   (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;

Drug	**NDC**	**Generic(G) /Brand(B)**	**Price /Unit**	**Units Billed**	**AWP Formula**	**Billed Amt**	**Lesser of AWP and Billed**
Diclofenac Sodium 1% Gel	21922000909	G	0.583	200	$149.88	$174.20	$149.88
						$174.20	$149.88

The total reimbursement is $149.88. 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 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 XL Specialty Insurance Co must remit to Memorial Wellness Pharmacy $149.88 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 26, 2023
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.