



# TEXAS DEPARTMENT OF INSURANCE

## Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

American Specialty Pharmacy

**Respondent Name**

Texas Political Subdivision Joint Self Insurance Funds

**MFDR Tracking Number**

M4-15-2131-01

**Carrier's Austin Representative**

Box Number 53

**MFDR Date Received**

March 13, 2015

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "... this treatment is necessary to achieve a therapeutic outcome ... This medication is medically necessary in order to decrease pain, reduce the need for narcotics and/or other prescription analgesics and to preserve the function of the patient..."

**Amount in Dispute:** \$1344.32

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Based on the submitted documentation no additional payment is being made at this time. Per the rule §134.530 1 (B) preauthorization is required for any compound that contains a drug identified with a status of 'N' in the current edition of the ODG Treatment in Workers' Compensation Drug Formulary, and any updates. Per the rule, the compound in dispute does require preauthorization as it contains two status 'N' drugs, Ketamine and Lidocaine."

**Response Submitted by:** Injury Management Organization

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 6, 2015	Prescription Medication (Compound Cream)	\$1344.32	\$0.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.530 sets out the requirements for use of the closed formulary for claims not subject to certified networks.
3. 28 Texas Administrative Code §134.600 sets out the procedures regarding preauthorization of health care.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- 197 – Precertification/authorization/notification absent

**Issues**

Are the insurance carrier’s reasons for denial or reduction of payment supported?

**Findings**

The insurance carrier denied disputed services with claim adjustment reason code 197 – “Precertification/authorization/notification absent.” 28 Texas Administrative Code §134.540 (b) states, Preauthorization for claims subject to the Division's closed formulary.

(1) 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;
- (B) **any compound that contains a drug 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;** [emphasis added] and
- (C) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

Review of the submitted documentation finds that the dispute involves a compound drug that includes the ingredients Flurbiprofen, Ketamine, Lidocaine, Gabapentin, Ethoxy Diglycol, Propylene Glycol, and Versapro Cream. The *ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary* in effect on the date of service finds that Ketamine and Lidocaine are “N” status drugs. Therefore, the compound requires preauthorization.

Review of the submitted information does not find that a request for preauthorization was requested or obtained in accordance with 28 Texas Administrative Code §134.600. For this reason, the insurance carrier’s denial reason is supported. Additional reimbursement cannot be recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Laurie Garnes  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
December 9, 2015  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**