



**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 Municipal League Intergovernmental

**MFDR Tracking Number**

M4-15-2325-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

March 27, 2015

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** No position statement submitted.

**Amount in Dispute:** \$1,344.32

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

**Response Submitted by:** Flahive, Ogden & Latson

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 6, 2015	Flurbiprofen, Ketamine, Lidocaine, Gabapentin, Ethoxy Diglycol, Propylene Glycol, Versapro Cream	\$1,344.32	\$0.00

**FINDINGS AND DECISION**

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

**Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.530 sets out requirements for use of the closed formulary for claims not subject to certified networks.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes;
  - 197 – No preauthorization of file

**Issues**

1. Did the carrier support the denial reason?
2. Is the requestor entitled to reimbursement?

**Findings**

1. The carrier denied the disputed service as 197 – “No preauthorization on file.”

Review results of TX COMP claim profile at <https://txcomp.tdi.state.tx>, no active certified network. Therefore, the applicable rule is 28 Texas Administrative Code §134.530 which states in pertinent part, “(b) 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; 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 medical claim finds;

- a. Appendix A, ODG Workers' Compensation Drug Formulary lists – “Ketamine, Lidocaine and Gabapentin” – with a status of “N”.
- b. State of Pharmacy Services / DWC066 (no prior authorization present)

As this was a compounded cream with “N” status ingredients, prior authorization was required but was not obtained. The Carrier’s denial is supported.

2. As no documentation was found to support the requirements of Pharmacy Rule 134.530 were met, no additional payment can 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	Medical Fee Dispute Resolution Officer	June 11, 2015 Date
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### **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, effective May 31, 2012, 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 MDR 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.**