TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
American Specialty Pharmacy

Respondent Name
Zurich American Insurance Company

MFDR Tracking Number
M4-15-2953-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 12, 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: $3022.14

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…Please see the EOBs. The provider failed to obtain preauthorization…"

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 21, 2014	Prescription Medication (Compound Cream)	$3022.14	$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
   - 39 – Services denied at the time authorization/pre-certification was requested.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The insurance carrier denied the disputed services with claim adjustment code "197 – Percertification/authorization/notification absent." 28 Texas Administrative Code §134.530 (b) (1) states, in relevant part, "Preauthorization is only required for: … (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." 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.

   28 Texas Administrative Code §134.530 (e)(1) states, "For situations in which the prescribing doctor determines and documents that a drug excluded from the closed formulary is necessary to treat an injured employee's compensable injury and has prescribed the drug, the prescribing doctor, other requestor, or injured employee must request approval of the drug by requesting preauthorization, including reconsideration, in accordance with §134.600 of this title and applicable provisions of Chapter 19 of this title (relating to Agents' Licensing)." 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

	Laurie Garnes	June 11, 2015
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 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.