



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

Dallas ISD

MFDR Tracking Number

M4-15-2962-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

May 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...This treatment is necessary to achieve a therapeutic outcome ... This medication is necessary in order to decrease pain, injury related strains, spasms, and to preserve function of the patient..."

Amount in Dispute: \$791.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The issue is in regards to the reimbursement for Medrox Patch that is a combination of Capsaicin and menthol..."

Per 28 TAC §134.530 (1)(A), preauthorization is required for drugs identified with a status of 'N' in the current edition of the ODG.

According to the Official Disability Guidelines the drug Capsaicin is an 'N' status drug. Since the requestor did not seek pre-authorization, drug was correctly denied..."

Response Submitted by: Argus Services Corporation

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: January 23, 2015, Prescription Medication (Medrox Patch), \$791.90, \$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 §134.540 sets out the guidelines for use of the closed formulary for claims

subject to certified networks.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 219A – Based on extent of injury. *Supplies/Services are not (or appear not to be) related to the compensable injury.*
 - 50K – These are non-covered services because this is not deemed a ‘medical necessity’ by the payer. *Not recommended per the Official Disability Guidelines (ODG)*
 - 197D – Precertification/authorization/notification absent. *Health care treatments/services that are not recommended, not listed, or under study by the ODG, or exceeded the ODG in frequency or duration require pre-authorization.*

Issues

1. Is there an unresolved extent of injury issue for this dispute?
2. Is there an unresolved medical necessity issue for this dispute?
3. Is the insurance carrier’s denial of payment for lack of preauthorization supported?

Findings

1. On the Explanation of Benefits dated February 19, 2015, the insurance carrier denied disputed services with claim adjustment reason code “219A Based on extent of injury. *Supplies/Services are not (or appear not to be) related to the compensable injury.*” 28 Texas Administrative Code §133.307 (f)(3) states, in relevant part, “...The division may dismiss a request for MFDR if: ... (C) the request contains an unresolved compensability, extent of injury, or liability dispute for the claim...” Review of the submitted documentation finds that this denial was not maintained on the reconsideration Explanation of Benefits, dated March 20, 2015. Therefore, the Division finds that no unresolved extent of injury issue exists for this dispute.
2. On the Explanation of Benefits dated February 19, 2015, the insurance carrier denied disputed services with claim adjustment reason code “50K These are non-covered services because this is not deemed a ‘medical necessity’ by the payer. *Not recommended per the Official Disability Guidelines (ODG)*.” 28 Texas Administrative Code §133.307 (f)(3) states, in relevant part, “...The division may dismiss a request for MFDR if: ... (B) the request contains an unresolved adverse determination of medical necessity...” Review of the submitted documentation finds that this denial was not maintained on the reconsideration Explanation of Benefits, dated March 20, 2015. Therefore, the Division finds that no unresolved medical necessity issue exists for this dispute.
3. The insurance carrier denied disputed services with claim adjustment reason code “197D – Precertification/authorization/notification absent. *Health care treatments/services that are not recommended, not listed, or under study by the ODG, or exceeded the ODG in frequency or duration require pre-authorization.*” 28 Texas Administrative Code §134.540 (b) states, in relevant part, “Preauthorization for claims subject to the Division's closed formulary. Preauthorization is only required for: ... (2) 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 Methyl Salicylate, Menthol, and Capsaicin. The *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary* in effect on the date of service finds that Capsaicin is an “N” status drug. Therefore, the compound requires preauthorization.

28 Texas Administrative Code §134.540 (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 in a specific instance by requesting preauthorization in accordance with the certified network's preauthorization process established pursuant to Chapter 10, Subchapter F of this title (relating to Utilization Review and Retrospective Review) and applicable provisions of Chapter 19 of this title (relating to Agents' Licensing).” Review of the submitted documentation does not indicate that a preauthorization was requested or obtained. 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 5, 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.