



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

State Office of Risk Management

MFDR Tracking Number

M4-15-2963-01

Carrier's Austin Representative

Box Number 45

MFDR Date Received

May 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: \$233.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "An in-depth review of the dispute packet revealed the charges in dispute are for an opioid medication that is not listed in the Division's Drug Formulary. ...we would like to note that we were unable to locate preauthorization for the medication Trezix on this claim as there is no information regarding this medication in the ODG Treatment in Workers' Compensation (ODG)/Appendix A, ODG Workers' Compensation Drug Formulary."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 3, 2015	Trezix	\$233.50	\$187.10

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. 28 Texas Administrative Code §134.540 sets out requirements for use of the closed formulary for claims subject to certified networks. The closed formulary applies to all drugs that are prescribed and dispensed for

outpatient use for claims subject to a certified network.

2. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
 - 967 – The charge has been disallowed in accordance with the occupational disability guidelines (ODG)
 - P12 – Workers’ compensation jurisdictional fee schedule adjustment
 - 4192 – The provider has billed for a brand name drug. A generic equivalent drug is not available. The allowance has been determined according to the pharmacy fee guidelines.
 - 285 – Please refer to the note above for a detailed explanation of the reduction. Note: The medications as being a compound medication that is not supported by the ODG and therefore requires preauthorization. There is not preauthorization on file.

Issues

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute involved the prescription pill “Trezix”. The commercially available, FDA-approved drug, is comprised of, Acetaminophen 320.5mg; Caffeine 30mg; and Dihydrocodeine bitartrate 16mg in an oral capsule. The insurance carrier denied disputed services with claim adjustment reason code 967 – “The charge has been disallowed in accordance with the occupational disability guidelines (ODG) and 285 – “Please refer to the note above for a detailed explanation of the reduction. Note: The medications as being a compound medication that is not supported by the ODG and therefore requires preauthorization. There is not preauthorization on file.”

Review of the ODG Pain Guidelines finds no mention of the name brand “Trezix” or the ingredients, “acetaminophen, caffeine, and dihydrocodeine bitartrate” as not being recommended. The carrier’s denial is not supported.

Review of the TX COMP claim profile at <https://txcomp.tdi.state.tx.>, shows an active Certified network. Therefore, the applicable rule is 28 Texas Administrative Code §134.540 (b) which states in pertinent part, Preauthorization is only required for:

- (1) 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;
- (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; and
- (3) 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. Trezix

Per Appendix A, ODG Workers’ Compensation Drug Formulary, the status of “Trezix” is not found. No preauthorization was required. The carrier’s denial is not supported. This claim line will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code §134.503 (c) states,
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: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;

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

(C) When compounding, a single compounding fee of \$15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection;

The services in dispute will be calculated as follows:

Dates of Service	Prescription Drug	§134.503 (c) (1)(B)	Carrier Paid	Due
January 3, 2015	Trezix 66992084010	$3.35970 \times 50 = \$167.985$ $(167.985 \times 1.09) = \$183.10 +$ $\$4.00 = \187.10	\$0.00	\$187.10
	TOTAL			\$187.10

3. The total amount allowed for the services in dispute is \$187.10. The carrier previously paid \$0.00. The amount due to the requestor is \$187.10 this amount is recommended.

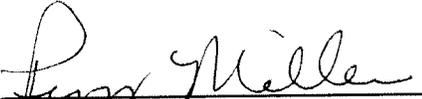
Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$187.10.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$187.10 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature


Signature

Peggy Miller
Medical Fee Dispute Resolution Officer

August 31, 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.