



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

Zurich American Insurance Company

MFDR Tracking Number

M4-15-3422-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

June 15, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "MELOXICAM 15 MG is medically necessary: ... to decrease pain ..."

Amount in Dispute: \$63.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see EOBs."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 4, 2015	Prescription Medication (Meloxicam)	\$63.90	\$63.90

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.10 sets out the requirements for submitting a medical bill.
- 28 Texas Administrative Code §133.210 sets out the procedures regarding documentation for medical bills.
- 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical benefits.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 436 – Drug not related to injury
 - 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.
 - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
 - 205 – Addtl info needed

Issues

1. Does a relatedness issue exist for this dispute?
2. Does a medical necessity issue exist for this dispute?
3. Did the requestor submit a complete medical bill in accordance with 28 Texas Administrative Code §133.10?
4. Is the insurance carrier's denial of payment due to lack of documentation supported?
5. What is the total reimbursement amount for the disputed service?
6. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed service on the explanation of benefits dated March 18, 2015 in part with claim adjustment reason code 436 – “DRUG NOT RELATED TO INJURY.” A review of submitted documentation finds that the insurance carrier did not maintain this denial on reconsideration. Therefore, the Division finds that a relatedness issue does not exist for this dispute.
2. The insurance carrier denied disputed service on the explanation of benefits dated March 18, 2015 in part with claim adjustment reason code 50 – “THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A ‘MEDICAL NECESSITY’ BY THE PAYER.” A review of submitted documentation finds that the insurance carrier did not maintain this denial on reconsideration. Therefore, the Division finds that a medical necessity issue does not exist for this dispute.
3. The insurance carrier denied disputed service on the explanation of benefits dated May 12, 2015 in part with claim adjustment reason code 16 – “CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.” 28 Texas Administrative Code §133.10 (c) and (f)(3) set out the requirements for submitting a bill for pharmaceutical services. Review of the submitted documentation finds that the requestor submitted a DWC066 in accordance with this rule. Therefore, the insurance carrier's denial for this reason is not supported.
4. The insurance carrier denied disputed service on the explanation of benefits dated May 12, 2015 in part with claim adjustment reason code 205 – “ADDTL INFO NEEDED.” Documentation requirements are established by 28 Texas Administrative Code §133.210 which describes the documentation required to be submitted with a medical bill. 28 Texas Administrative Code §133.210 does not require documentation to be submitted with the medical bill for the services in dispute.

Further, the process for a carrier's request of documentation not otherwise required by 28 Texas Administrative Code §133.210 is described in section (d) of that section as follows:

“Any request by the insurance carrier for additional documentation to process a medical bill shall:

- (1) be in writing;
- (2) be specific to the bill or the bill's related episode of care;
- (3) describe with specificity the clinical and other information to be included in the response;
- (4) be relevant and necessary for the resolution of the bill;
- (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
- (6) indicate the specific reason for which the insurance carrier is requesting the information; and
- (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation.”

No documentation was found to support that the carrier made an appropriate request for additional documentation with the specificity required by §133.210(d). The Division concludes that carrier failed to meet the requirements of 28 Texas Administrative Code 133.210(d). The carrier's denial for this reason is not supported. Therefore, the disputed charges will be reviewed in accordance with applicable rules and fee guidelines.

5. The total reimbursement for the disputed services is established by the AWP formula pursuant to 28 Texas Administrative Code §134.503 (c), which states, in relevant part:

- (c) 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...
 - (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
 - (A) health care provider

The requestor is seeking reimbursement for a compound of the generic drug Meloxicam, 15 mg, NDC 68382005105. The disputed medication was dispensed on February 4, 2015. The reimbursement is calculated as follows:

Date of Service	Prescription Drug	Calculation per §134.503 (c)(1)	§134.503 (c)(2)	Lesser of §134.503 (c)(1) & (2)	Carrier Paid	Balance Due
2/4/15	Meloxicam	$(4.84490 \times 30 \times 1.25) + \$4.00 = \$185.68$	\$63.90	\$63.90	\$0.00	\$63.90

6. The total reimbursement for the disputed service is \$63.90. The insurance carrier paid \$0.00. A reimbursement of \$63.90 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 \$63.90.

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 \$63.90 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	October 23, 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, 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.