



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

Indemnity Insurance Co of North

MFDR Tracking Number

M4-15-3690-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

July 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: \$474.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was sent to the utilization department for retrospective review. It was determined that the medications were not medically necessary. The provider did not appeal the denial. The medications continue to be filled without documentation of medical necessity."

Response submitted by: ESIS, P.O. Box 31143, Tampa, FL 33631-3143

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 21, 2015	Tizanidine HCl 4mg, Trezix, Meloxicam 15mg, Amitriptyline HCl 50mg	\$474.90	\$474.90

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 §133.240 sets out requirements for medical payments and denials.
- 28 Texas Administrative Code §134.530 sets out requirements for use of the closed formulary for claims not subject to certified networks. The closed formulary applies to all drugs that are prescribed and dispensed for outpatient use for claims not subject to a certified network.
- 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
- The insurance carrier included an explanation of benefits however, no remark codes or notes was given.

Issues

1. Is the respondent's position statement supported?
2. Did the carrier comply with Division guidelines in their explanation of benefits?
3. What is the applicable rule pertaining to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §133.307 (F) states,

The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section.

Review of the submitted documentation finds the requestor's position represents a denial that was not presented to the requestor prior to the request for MFDR. Therefore, the position of the respondent will not be considered in this dispute.

2. 28 Texas Administrative Code §133.240 (f) states in pertinent part,

The paper form of an explanation of benefits under subsection (e) of this section, §133.250 of this title (relating to Reconsideration for Payment of Medical Bills), or §133.260 of this title (relating to Refunds) shall include the following elements:

(17) health care service information for each billed health care service, to include:

(G) adjustment reason code that conforms to the standards described in §133.500 and §133.501 of this title if total amount paid does not equal total amount charged;

(H) explanation of the reason for reduction/denial if the adjustment reason code was included under subparagraph (G) of this paragraph and if applicable;

Review of the submitted explanation of benefits for the services in dispute with Review date June 20, 2015 has a recommend/allowance of \$0.00 for each claim line. No remark codes were found on the claim line or in the Notes/Messages portion of the EOB. Therefore, the Division finds the Carrier did not comply with Rule 133.240 (f)(17)(G)(H). The services in dispute will be reviewed per applicable rules and fee guidelines.

3. The services in dispute are commercially available, FDA-approved drugs, Tizanidine HCl 4mg, Trezix, Meloxicam 15mg, Amitriptyline HCl 50mg. 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: $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs: $((AWP \text{ 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)	Maximum Allowable Reimbursement
May 21, 2015	Meloxicam 68382005105	4.84490 x 30 = \$145.347 \$145.347 x 1.25 = \$181.68 \$181.68 + 4 = \$185.68	\$185.68
May 21, 2015	Amitriptyline 16714044801	1.08480 x 30 = \$32.544 \$32.544 x 1.25 = \$40.68 \$40.68 + 4 = \$44.68	\$44.68
May 21, 2015	Tizanidine 60505025202	1.46524 x 30 = \$43.9572 \$43.9572 x 1.25 = \$54.95 \$54.95 + 4 = \$58.96	\$58.95
May 21, 2015	Trezix	3.35970 X 50 = \$167.985 \$167.985 x 109% = \$183.10 \$183.10 + 4 = \$187.10	\$187.10
	TOTAL		\$476.41

4. The total amount allowed for the services in dispute is \$476.41. The requestor is seeking \$474.90. 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 \$474.90.

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 \$474.90 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature

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.