



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

Ascension Health

MFDR Tracking Number

M4-15-3868-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

July 27, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Clonazepam ... is medically necessary: ... for anxiety secondary to injury ... to allow activities of daily living ...

Zolpidem ... is medically necessary: ... for insomnia due to pain ... to allow activities of daily living ..."

Amount in Dispute: \$214.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on August 4, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: April 8, 2015, Prescription Medication (Clonazepam & Zolpedem Tartrate ER), \$214.90, \$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 §134.530 sets out the requirements for use of the closed formulary for claims not subject to certified networks.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- D03 – Reviewed and denied by carrier or TPA.
  - F – Reduced according to fee guideline.
  - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
  - Payment disallowed. Lack of authorization: No authorization given for service rendered
  - P12 – Workers’ compensation jurisdictional fee schedule adjustment.

**Issues**

Are the insurance carrier’s reasons for denial or reduction of payment supported?

**Findings**

28 Texas Administrative Code §134.530 (b) (1) states, in relevant part,

Preauthorization is only required for: ...

- (A) 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
- (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; and
- (C) 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 documentation finds that the dispute involves the prescription medications Clonazepam and Zolpidem Tartrate ER. The *ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary* in effect on the date of service finds that Conazepam and Zolpidem Tartrate ER are “N” status drugs. Therefore, the medications require preauthorization.

Review of the submitted information does not find that a request for preauthorization was requested or obtained in accordance with 28 Texas Administrative Code §134.530. 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**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Laurie Garnes  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
September 30, 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.**