



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 Star Pharmacy

Respondent Name

Republic Indemnity Company of California

MFDR Tracking Number

M4-15-4213-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

August 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This treatment is necessary to achieve a therapeutic outcome ...

This medication is necessary for decreased scar lesion, pain, and scar management therapy due to surgery. This medication will allow reduced usage of other treatments and medications needed for this injured patient."

Amount in Dispute: \$475.49

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "... the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 5, 2015	Prescription Medication (Compound Cream)	\$475.49	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.540 sets out the guidelines for use of the closed formulary for claims subject to certified networks.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 1 – A dispensing fee is not applicable to an over-the-counter medication or to medication administered/dispensed at the time of the visit.
 - 3 – Charge for pharmaceuticals exceed the fees established by the fee schedule/UCR rates.

- 91 – Dispensing fee adjustment.
- 197 – Payment denied/reduced for absence of precertification/authorization.
- P12 – Workers’ Compensation jurisdictional fee schedule adjustment.

Issues

Is the insurance carrier’s reason for denial of payment supported?

Findings

The insurance carrier denied disputed services with claim adjustment reason code 197 – “PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.” 28 Texas Administrative Code §134.540 (b) states,

Preauthorization for claims subject to the Division's closed formulary. 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;** [emphasis added] 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 documentation finds that the dispute involves a compound drug that includes the ingredients Misoprostol-HPMC, Lidocaine HCl, Phentoin Sodium, Nifedipine, Levocetirizine DiHCl, Propylene Glycol, and Versapro Cream. The *ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary* in effect on the date of service finds that Lidocaine and Phentoin Sodium are “N” status drugs. Therefore, the compound requires preauthorization.

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	September 29, 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.