



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

Ace American Insurance Co

MFDR Tracking Number

M4-16-0085-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

September 11, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: \$159.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In conclusion, reimbursement should not be awarded for medications in which preauthorization was required, but was not obtained."

Response submitted by: Downs ♦ Stanford, PC

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include dates May 26, 2015 and July 17, 2015, and services Promethazine HCL 25 mg and Diphenhydramine hcl 25 mg.

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 denied the services in dispute with the following remark codes:
 - D20 – Previously denied by adjuster with PBM
 - D81 – Payment disallowed: Lack of authorization: No authorization given for service rendered
 - P12 – Workers’ compensation jurisdictional fee schedule adjustment

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. The carrier denied the services in dispute as D20 – “Previously denied by adjuster with PBM.” 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; 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 claim forms finds;

- a. Date of service May 26, 2015, Promethazine HCL 25 mg – Review of Appendix A, ODG Workers’ Compensation Drug Formulary finds “Promethazine for insomnia” Status - N
- b. Date of service July 17, 2015, Diphenhydramine hcl 25 mg – Review of Appendix A, ODG Workers’ Compensation Drug Formulary finds “Diphenhydramine for insomnia” Status – N
- c. Review of Letter of Medical Necessity dated June 16, 2015 for Promethazine 25mg indicates, “for medication induced nausea”. Based on prescribed use medication not considered an “N” drug and does not require prior authorization.
- d. Review of Letter of Medical Necessity dated July 23, 2015 for Diphenhydramine HCL 25 mg indicates, “for insomnia due to pain.” Based on prescribed use medication is considered an “N” drug and does require prior authorization.

The Division finds the prescription for May 26, 2015 will be reviewed per applicable rules and fee guidelines. The prescription for July 17, 2015 was subject to prior authorization and the carrier’s denial is supported.

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: $((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)(A)	Maximum Allowable Reimbursement
May 26, 2015	Promethazine HCL 25 mg	$0.48108 \times 30 \times \$1.25 + \$4.00 =$ \$22.04	\$22.04
	TOTAL		\$22.04

3. The total amount allowed for the services in dispute is \$22.04. 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 \$22.04.

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 \$22.04 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

October 27, 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.