



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

Memorial Compounding Pharmacy

Respondent Name

ACE American Insurance Company

MFDR Tracking Number

M4-16-0228-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

September 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THIS MEDICATION DOES NOT FALL INTO ANY OF THE CATORGORIES REGARDING PREAUTHORIZATION."

Amount in Dispute: \$990.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of the bill, it was sent for retrospective review through the utilization review company. It was determined that the medication was not medically necessary. Therefore, it is the Carrier' position that the provider is not entitled to reimbursement."

Response Submitted by: ACE/ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 14 & 30, 2015	Prescription Medication (Meloxicam)	\$990.88	\$990.88

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 §134.503 sets out the guidelines for billing and reimbursing pharmaceutical services.
- 28 Texas Administrative Code §134.530 sets out the requirements for use of the closed formulary for claims not subject to certified networks.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 62 – No proof of pre-auth

Issues

1. Does a medical necessity issue exist for this dispute?
2. Is the insurance carrier's reason for denial of payment supported?
3. What is the total reimbursement for the disputed service?
4. Is the requestor entitled to reimbursement?

Findings

1. In their position statement, the requestor stated, "Upon receipt of the bill, it was sent for retrospective review through the utilization review company. It was determined that the medication was not medically necessary." 28 Texas Administrative Code §133.307(d)(2)(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."

Review of the submitted documentation finds that medical necessity was not a denial reason presented to the requestor prior to the date the request for MFDR was filed. Therefore, this issue will not be considered for this dispute.

2. The dispute involves reimbursement of the medication "MELOXICAM USP 100%." The insurance carrier denied disputed services with claim adjustment reason code 62 – "NO PROOF OF PRE-AUTH." 28 Texas Administrative Code §134.530(b)(1) states that 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).

The division finds that Meloxicam has a status of "Y" in the current edition of the *ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary* effective on the date of service. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

3. 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:

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 NDC 38779274601, representing "Meloxicam (Bulk) Powder." 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
4/14/15	Meloxicam (Bulk) Powder	$(194.67000 \times 60 \times 1.25) + \$4.00 = \$14,604.25$	\$495.44	\$495.44	\$0.00	\$495.44
4/30/15	Meloxicam (Bulk) Powder	$(194.67000 \times 60 \times 1.25) + \$4.00 = \$14,604.25$	\$495.44	\$495.44	\$0.00	\$495.44

4. The total reimbursement amount is \$990.88. The insurance carrier paid \$0.00. A reimbursement of \$990.88 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 \$990.88.

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 \$990.88 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

January 11, 2016
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.