



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

TPCIGA for Lumbermens Mutual Casualty Company

MFDR Tracking Number

M4-16-0260-01

Carrier's Austin Representative

Box Number 50

MFDR Date Received

September 29, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This treatment is necessary to achieve a therapeutic outcome ... This medication is medically necessary in order to decrease pain, reduce the need for narcotics and/or other prescription analgesics and to preserve function of the patient."

Amount in Dispute: \$2964.00

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 October 6, 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 14, 2015, Prescription Medication (Compound Cream), \$2964.00, \$2261.46

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 §133.10 defines the requirements for a pharmacy bill.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmacy services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 16 – Claim/service lacks information which is needed for adjudication.
  - 940 – Please re-submit with the appropriate NDC number. No AWP for this NDC.
  - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
  - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
  - 5246 – In order for us to process your workers’ compensation bill in a timely manner we need additional information. Be sure the following are on your submittal for review and/or payment: Pharmacy NCPDP# (formerly NABP#), prescribing doctor’s name, prescribing doctor’s DEA#, RX number, days supply.

**Issues**

1. Is the insurance carrier’s reason for denial of payment for NDC number supported?
2. Is the insurance carrier’s reason for denial of payment for billing information supported?
3. What is the total reimbursement for the disputed services?
4. Is the requestor entitled to additional reimbursement?

**Findings**

1. The insurance carrier denied disputed services with claim adjustment reason code 940 – “PLEASE RE-SUBMIT WITH THE APPROPRIATE NDC NUMBER. NO AWP FOR THIS NDC.” Review of the submitted information finds that all NDC numbers included in the submitted Statement of Pharmacy Services (DWC066) were correct for the drugs listed. The insurance carrier’s denial for this reason is not supported.
2. The insurance carrier denied disputed services with claim adjustment reason codes 16 – “CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION,” and 5246 – “IN ORDER FOR US TO PROCESS YOUR WORKERS’ COMPENSATION BILL IN A TIMELY MANNER WE NEED ADDITIONAL INFORMATION. BE SURE THE FOLLOWING ARE ON YOUR SUBMITTAL FOR REVIEW AND/OR PAYMENT: PHARMACY NCPDP# (FORMERLY NABP#), PRESCRIBING DOCTOR’S NAME, PRESCRIBING DOCTOR’S DEA#, RX NUMBER, DAYS SUPPLY.”

28 Texas Administrative Code §133.10 (f)(3) defines the required information for a pharmacy bill. Review of the submitted documentation finds that Statement of Pharmacy Services (DWC066) included all required information. The insurance carrier’s denial reason is not supported. The disputed services will therefore be reviewed per applicable Division 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:
  - (c) 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...
    - (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 a compound of the generic drugs Flurbiprofen, NDC 38779273909; Ketamine, NDC 38779175409; Lidocaine, NDC 38779008209; Gabapentin, NDC 38779246109; Nifedipine, NDC 38779028003; Pentoxifylline, NDC 38779256005; Alpha Lipoic Acid, NDC 38779253505;

Ethoxy Diglycol, NDC 38779190301; Propylene Glycol, NDC 38779051001; and brand name drug Versapro Cream, NDC 38779252903. The disputed medication was dispensed on April 14, 2015. 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	Flurbiprofen	$(36.58000 \times 7.5 \times 1.25) + \$4.00 = \$346.94$	\$274.35	\$274.35	\$0.00	\$274.35
4/14/15	Ketamine	$(33.51600 \times 15.0 \times 1.25) + \$4.00 = \$632.43$	\$502.65	\$502.65	\$0.00	\$502.65
4/14/15	Lidocaine	$(4.27500 \times 15.0 \times 1.25) + \$4.00 = \$84.16$	\$64.05	\$64.08	\$0.00	\$64.08
4/14/15	Gabapentin	$(59.85000 \times 15.0 \times 1.25) + \$4.00 = \$1126.19$	\$897.75	\$897.75	\$0.00	\$897.75
4/14/15	Nifedipine	$(44.17600 \times 3.0 \times 1.25) + \$4.00 = \$169.66$	\$85.50	\$85.50	\$0.00	\$85.50
4/14/15	Pentoxifylline	$(8.28400 \times 3.0 \times 1.25) + \$4.00 = \$35.07$	\$23.94	\$23.94	\$0.00	\$23.94
4/14/15	Alpha Lipoic Acid	$(42.750000 \times 3.0 \times 1.25) + \$4.00 = \$164.31$	\$866.88	\$164.31	\$0.00	\$164.31
4/14/15	Ethoxy Diglycol	$(0.34200 \times 6.0 \times 1.25) + \$4.00 = \$6.57$	\$2.94	\$2.94	\$0.00	\$2.94
4/14/15	Propylene Glycol	$(0.19000 \times 6.0 \times 1.25) + \$4.00 = \$5.43$	\$1.14	\$1.14	\$0.00	\$1.14
4/14/15	Versapro Cream	$(3.20000 \times 76.5 \times 1.09) + \$4.00 = \$269.09$	\$244.80	\$244.80	\$0.00	\$244.80

4. The total reimbursement amount for the disputed service is \$2261.46. The insurance carrier paid \$0.00. A reimbursement of \$2261.46 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 \$2261.46.

***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 \$2261.46 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

November 13, 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.**