



**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name**

American Specialty Pharmacy

**Respondent Name**

Hartford Underwriters Insurance

**MFDR Tracking Number**

M4-16-0900-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

December 7, 2015

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** No position statement submitted.

**Amount in Dispute:** \$619.88

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Our investigation found the following: To date, no record of receipt of requested documentation."

**Response Submitted by:** The Hartford

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 2, 2015	Flurbiprofen, Cyclobenzaprine, Menthol, Lidocaine, Ethoxy Diglycol, Ethanol, Dimethyl Sulfoxide	\$619.88	\$619.88

**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 §133.10 sets out requirements related to billing forms and formats.
- 28 Texas Administrative Code §134.502 sets out billing requirements for pharmacy services.
- 28 Texas Administrative Code §134.503 sets out fee guidelines for pharmaceutical services.
- 28 Texas Administrative Code §133.210 sets out our requirements for medical documentation.
- 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
  - 295 – Service cannot be reviewed without report or invoice. Please submit report/invoice as soon as possible to ensure accurate processing

- 483 – Medical report required for payment

### **Issues**

1. Was the service in dispute submitted pursuant to applicable rules?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. What is the applicable rule pertaining to reimbursement?
4. Is the requestor entitled to additional reimbursement?

### **Findings**

1. The services in dispute are for pharmaceutical services. 28 Texas Administrative Code §133.10 (f)(3)(AA) states,

All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form.

(3) The following data content or data elements are required for a complete pharmacy medical bill related to Texas workers' compensation health care:

(AA) for billing of compound drugs refer to the requirements in §134.502 of this title (relating to Pharmaceutical Services).

28 Texas Administrative Code 134.502 (d)(1) (2)states,

Pharmacies and pharmacy processing agents shall submit bills for pharmacy services in accordance with Chapter 133 (relating to General Medical Provisions) and Chapter 134 (relating to Benefits--Guidelines for Medical Services, Charges, and Payments).

- (1) Health care providers shall bill using national drug codes (NDC) when billing for prescription drugs.
- (2) Compound drugs shall be billed by listing each drug included in the compound and calculating the charge for each drug separately.

Review of the submitted DWC066 finds;

- The requestor did submit using national drug codes (NDC) and each compound were listed separately.

The requestor met the requirements of Rule 133.10 and 134.502.

2. The insurance carrier denied disputed services with claim adjustment reason code 295 – “Service cannot be reviewed without report or invoice. Please submit report/invoice as soon as possible to ensure accurate processing” and 483 – “Medical report required for payment.”

28 Texas Administrative Code 133.210 (d) states,

Any request by the insurance carrier for additional documentation to process a medical bill shall:

- (1) be in writing;
- (2) be specific to the bill or the bill's related episode of care;
- (3) describe with specificity the clinical and other information to be included in the response;
- (4) be relevant and necessary for the resolution of the bill;
- (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
- (6) indicate the specific reason for which the insurance carrier is requesting the information; and
- (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation.

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:  $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \$4.00$  dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs:  $((\text{AWP per unit}) \times (\text{number of units}) \times 1.09) + \$4.00$  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;

While the respondent did request additional information during the bill review process, the request for an "invoice" is not required to establish the fee schedule amount. Rather as stated above, "the fee established by the following formulas based on the average wholesale price (AWP).

The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

3. Pursuant to Rule 134.503 (c), the reimbursement will be calculated as follows.

Date of Service	Prescription Drug	Fee schedule allowable per Rule 134.503(c) Generic drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25)$	Amount due
April 2, 2015	Fluribiprofen	$(36.58 \times 9) \times 1.25 = \$411.53 = \$15.00$ one compounding fee = \$426.53	\$426.53
April 2, 2015	Cyclobenzaprine	$(46.332 \times 2) \times 1.25 = \$115.83$	\$115.83
April 2, 2015	Menthol	$(2.28 \times 4) \times 1.25 = \$11.40$	\$11.40
April 2, 2015	Lidocaine	$(4.275 \times 24) \times 1.25 = \$128.25$	\$128.25
April 2, 2015	Ethoxy Diglycol	$(0.342 \times 12) \times 1.25 = \$5.13$	\$5.13
April 2, 2015	Ethanol	$(0.36 \times 12) \times 1.25 = \$5.40$	\$5.40
April 2, 2015	Dimethyl Sulfoxide	$(1.24 \times 24) \times 1.25 = \$37.20$	\$37.20
		Total	\$729.74

4. The allowable reimbursement for the services in dispute is \$729.74. The requestor is seeking \$619.88. 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 \$619.88.

**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 \$619.88 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

December 29, 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.**