



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

M4-16-2216-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

March 8, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached bill was denied by the carrier stating preauthorization was not obtained. Reconsideration was submitted but denied. We are now requesting Medical Fee Dispute Resolution."

Amount in Dispute: \$489.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "On 9/11/15, a retrospective review was completed for the medication that was filled on 6/24/15. The bill for DOS 9/28/15 was received with no additional medical documentation to support the medical necessity of the compound medication. Therefore, the bill was denied. The denial code used was lack of preauthorization. That code was used in error. The correct code should be denial 'Unnecessary Medical Treatment with a Peer review'. Attached are a corrected EOR and a copy of the Utilization Review. It is the Carrier position that the provider has not estimated medical necessity and therefore, is not entitled to reimbursement."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 28, 2015	Prescription Medication (Baclofen)	\$489.96	\$489.96

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.

3. 28 Texas Administrative Code §134.530 sets out the requirements for use of the closed formulary for claims not subject to certified networks.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 62 – No proof of pre-auth
 - 18 – Duplicate claim/service.

Issues

1. Did the insurance carrier raise medical necessity in accordance with 28 Texas Administrative Code §133.307?
2. Is the insurance carrier’s reason for denial of payment supported?
3. What is the total allowance for the disputed service?
4. Is the requestor entitled to reimbursement for the disputed service?

Findings

1. In their position statement, the insurance carrier argues that “the provider has not estimated medical necessity and therefore, is not entitled to reimbursement.” 28 Texas Administrative Code §133.307(d)(2)(F) states, in relevant part: “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, the carrier did not raise medical necessity in accordance with 28 Texas Administrative Code §133.307 and this denial reason will not be considered for this dispute.

2. 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:

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 Baclofen is included in the closed formulary and have 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. Therefore, preauthorization is not required for the disputed 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 the generic drug Baclofen Powder, NDC 38779038809, 60 grams for a 5-day supply. The disputed medication was dispensed on September 28, 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
9/28/15	Baclofen Powder	$(35.63 \times 60.0 \times 1.25) + \$4.00 = \$2676.25$	\$489.96	\$489.96	\$0.00	\$489.96

4. The total allowable for the disputed service is \$489.96. The insurance carrier paid \$0.00. A reimbursement of \$489.96 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 \$489.96.

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 in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$489.96 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

 April 20, 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.