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
INJURED WORKERS PHARMACY LLC

Respondent Name
State of Risk Management

MFDR Tracking Number
M4-20-1696-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
March 9, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Based on the diagnosis in which treatment is being prescribed, the medications being shipped are all 'Y' status drugs per the Texas Formulary. With that being said, the medications do not require authorization prior to shipping."

Amount in Dispute: $11,006.55

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office performed an in-depth review of the dispute packet submitted by the Injured Worker Pharmacy and will respectfully request dates of service 10/22/2018-1/21/2019 of this medical fee dispute be dismissed due to it is not eligible for review pursuant to Rule §133.307 (c)(1). Further review of the dates of service eligible were denied for needing preauthorization for the N status medications. The Office will maintain these denials at this time as there was no preauthorization obtained for these medications pursuant to Rule §134.530."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 22, 2018 – January 21, 2019	Prescription Medications	$7,240.04	$0.00
April 15, 2019	Divalproex Sodium DR 250 mg Tablets x 180	$396.11	$396.11
April 15, 2019	Myrbetriq ER 50 mg Tablets x 90	$1,511.95	$1,511.95
July 9, 2019	Divalproex Sodium DR 250 mg Tablets x 180	$400.50	$400.50
July 17, 2019	Myrbetriq ER 50 mg Tablets x 90	$1,511.95	$1,511.95
	Total	$11,006.55	$3820.51

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 (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
3. 28 Texas Administrative Code §134.530 sets out the preauthorization requirements for pharmaceutical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization.
   - 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
   - W3 – Additional payment made on appeal/reconsideration.
   - 252 – An attachment/other documentation is required to adjudicate this claim/service.

Issues

1. Did the requestor forfeit its right to medical fee dispute resolution for the dates of service in question?
2. Is the insurance carrier's denial of payment based on documentation supported?
3. Is the insurance carrier's denial of payment based on preauthorization supported?
4. Is the requestor entitled to reimbursement for the disputed drugs?

Findings

1. Injured Workers' Pharmacy is seeking reimbursement for drugs dispensed on the following dates of service:

October 22, 2018	January 15, 2019	April 15, 2019
October 25, 2018	January 18, 2019	July 9, 2019
December 11, 2018	January 21, 2019	July 17, 2019

   The health care provider must request medical fee dispute resolution within one year from the date of service, with the following exceptions:

   - a related compensability, extent of injury, or liability dispute exists;
   - a medical dispute regarding medical necessity has been filed; or
   - the dispute relates to a refund notice issued pursuant to a division audit or review.[1]

   The DWC received the medical fee dispute resolution request on March 9, 2020. This is more than one year after dates of service October 22, 2018, through January 21, 2019. The DWC found no evidence to support that an exception applied to these dates of service. Injured Workers' Pharmacy has waived its right to medical fee dispute resolution for these dates of service.

   The DWC finds that dates of service April 15, 2019, through July 17, 2019, are eligible for review in this dispute.

2. State Office of Risk Management denied services, in part, due to lack of supporting documentation. The services in question do not require submission of medical documentation.[2] The process for an insurance carrier's request for additional documentation must:
   - be in writing,
   - be specific to the bill in question,

[1] 28 TAC §133.307 (c)(1)
[2] 28 TAC §133.210

- describe with specificity the information needed in the response,
- be relevant and necessary for the resolution of the bill,
- be for information that is part of the injured employee's medical or billing record held by the health care provider,
- indicate the specific reason the insurance carrier is requesting the information, and
- include a copy of the medical bill in question.

No evidence was found to support that the State Office of Risk Management made an appropriate request for additional documentation with the specificity required. The DWC concludes that the insurance carrier's denial for this reason is not supported.

3. State Office of Risk Management also denied the disputed drugs based on preauthorization. The insurance carrier argued that the drugs in question, Divalproex Sodium DR and Myrbetriq ER, were identified with a status of "N" in the current edition of the ODG Appendix A.[3]

   Drugs identified with a status of "N" in the current edition of the ODG Appendix A require preauthorization before dispensing.[4] The DWC finds that the drugs are not identified with a status of "N." The insurance carrier's preauthorization denial is therefore not supported.

4. Because State Office of Risk Management failed to support its denial reasons for the drugs in this dispute, the DWC finds that Injured Workers' Pharmacy is entitled to reimbursement.

   The reimbursement considered in this dispute is calculated as follows[5]:

Date of Service	Drug	NDC Number	Formula	Total
April 15, 2019	Divalproex Sodium DR 250 mg Tablets x 180	62756079713	(1.7427 x 180 x 1.25) + $4.00	$396.11
April 15, 2019	Myrbetriq ER 50 mg Tablets x 90	00469260290	(15.37156 x 90 x 1.25) + $4.00	$1,511.95
July 9, 2019	Divalproex Sodium DR 250 mg Tablets x 180	29300013905	(1.76222 x 180 x 1.25) + $4.00	$400.50
July 17, 2019	Myrbetriq ER 50 mg Tablets x 90	00469260290	(15.37156 x 90 x 1.25) + $4.00	$1,511.95
			Total	$3,820.51

   The total allowable reimbursement is $3,820.51. This amount is recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $3,820.51.

[3] *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary*
[4] 28 TAC §134.530 (b)(1)
[5] 28 TAC §134.503 (c)

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor $3,820.51, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		April 6, 2020
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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. **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.