TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Sentrix Pharmacy

Respondent Name
Texas Municipal League Intergovernmental Risk Pool

MFDR Tracking Number
M4-16-1996-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 15, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As of 02/03/16, according to the ODG-TWC, ODG Treatment 'compound drugs that use FDA approved ingredients may be considered…

The issuance of a valid prescription by the treating physician is evidence of medical necessity and a pharmacy is not required to provide anything further."

Amount in Dispute: $1717.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Prescribing Doctor, Dana Bleakney, MD is not an approved Alliance Provider. No bills or medical documentation have been received from Dr. Bleakney indicating the need for this medication…

Please note that this compounded cream does exceed the ODG level of care as Ketoprofen is not currently FDA approved for topical application."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 12, 2016	Prescription Medication (Compound Cream)	$1717.28	$1717.28

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 §133.210 sets out the documentation requirements for bill submission.

3. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
4. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
5. 28 Texas Administrative Code §134.530 sets out the requirements for use of the closed formulary for claims not subject to a certified health care network.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Service exceeds the Official Disability Guidelines (ODG) level of care
   - 16 – Please submit letter of medical necessity from prescribing doctor
   - 150 – Payer deems info submitted does not support level of service

Issues

1. Is the insurance carrier's denial for level of care supported?
2. Is the insurance carrier's denial regarding documentation supported?
3. Did the insurance carrier request a letter of medical necessity in accordance with 28 Texas Administrative Code §134.502?
4. What is the total allowable for the disputed services?
5. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code stating, "Service exceeds the Official Disability Guidelines (ODG) level of care." 28 Texas Administrative Code §134.530(d) states:

   > Treatment guidelines. Except as provided by this subsection, the prescribing of drugs shall be in accordance with §137.100 of this title (relating to Treatment Guidelines), the division's adopted treatment guidelines.
   > (1) Prescription and nonprescription drugs included in the division's closed formulary and recommended by the division's adopted treatment guidelines may be prescribed and dispensed without preauthorization.
   > (2) Prescription and nonprescription drugs included in the division's closed formulary that exceed or are not addressed by the division's adopted treatment guidelines may be prescribed and dispensed without preauthorization.
   > (3) Drugs included in the closed formulary that are prescribed and dispensed without preauthorization are subject to retrospective review of medical necessity and reasonableness of health care by the insurance carrier in accordance with subsection (g) of this section.

   Review of the submitted information does not find that the insurance carrier performed a retrospective review of medical necessity in accordance with 28 Texas Administrative Code §134.530. The insurance carrier's denial for this reason is not supported.

2. The insurance carrier denied disputed services with claim adjustment reason code 150 – "PAYER DEEMS INFO SUBMITTED DOES NOT SUPPORT LEVEL OF SERVICE." Documentation requirements for medical bills are established by 28 Texas Administrative Code §133.210, which does not require documentation to be submitted with the medical bill for the services in dispute.

   Further, the process for a carrier's request for documentation not otherwise required by 28 Texas Administrative Code §133.210 is described in Subsection (d) as follows:

   > 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.

No documentation was found to support that the carrier made an appropriate request for additional documentation with the specificity required by §133.210(d). The Division concludes that carrier failed to meet the requirements of 28 Texas Administrative Code 133.210(d). The carrier's denial for this reason is not supported.

3. The insurance carrier denied disputed services with claim adjustment reason code 16 – "PLEASE SUBMIT LETTER OF MEDICAL NECESSITY FROM PRESCRIBING DOCTOR." 28 Texas Administrative Code §134.502(e) states:

   > The insurance carrier, injured employee, or pharmacist may request a statement of medical necessity from the prescribing doctor. If an insurance carrier requests a statement of medical necessity, the insurance carrier shall provide the sender of the bill a copy of the request at the time the request is made. An insurance carrier shall not request a statement of medical necessity unless in the absence of such a statement the insurance carrier could reasonably support a denial based upon extent of, or relatedness to the compensable injury, or based upon an adverse determination.

   Review of the submitted information does not find that insurance carrier requested a letter of medical necessity in accordance with 28 Texas Administrative Code §134.502. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed in accordance with 28 Texas Administrative Code §134.530.

4. The total reimbursement for the disputed services is established by the AWP formula pursuant to 28 Texas Administrative Code §134.503(c), which 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: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
   > (B) Brand name drugs: ((AWP per unit) x (number of units) x 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; or
   > (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 Ketoprofen, NDC 38779007805; Amitriptyline, NDC 38779018908; Baclofen, NDC 38779038808; Amantadine, NDC 38779041109; Gabapentin, NDC 3877924108; and Versatile Base Cream, NDC 51552134308. The disputed medication was dispensed on January 12, 2016. 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
1/12/16	Ketoprofen	(10.45 x 18.0 x 1.25) + 4.00 = $239.13	$188.10	$188.10	$0.00	$188.10
1/12/16	Amitriptyline	(18.24 x 3.6 x 1.25) + 4.00 = $86.08	$65.66	$65.66	$0.00	$65.66
1/12/16	Baclofen	(35.63 x 7.2 x 1.25) + 4.00 = $324.67	$256.53	$256.53	$0.00	$256.53
1/12/16	Amantadine	(24.225 x 14.4 x 1.25) + 4.00 = $440.05	$348.84	$348.84	$0.00	$348.84

1/12/16	Gabapentin	(59.85 x 9.0 x 1.25) + 4.00 = $677.31	$538.65	$538.65	$0.00	$538.65
1/12/16	Versatile Base Cream	(2.50 x 127.8 x 1.09) + 4.00 = $403.38	$319.50	$319.50	$0.00	$319.50

5. The total allowable for the disputed services is $1717.28. The insurance carrier paid $0.00. A reimbursement of $1717.28 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 $1717.28.

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 $1717.28 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	June 10, 2016
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 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.