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**
Sentrix Pharmacy and Discount, L.L.C.

**Respondent Name**
Sentinel Insurance Company, Ltd.

**MFDR Tracking Number**
M4-16-3805-01

**Carrier's Austin Representative**
Box Number 47

**MFDR Date Received**
August 23, 2016

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The insurance carrier, The Hartford failed to take final action within the 45-day period set forth in TAC §134.240. Specifically the claim was submitted on 5/20/16 and it was received by the provider on 5/25/16 … and no action was taken on the claim. Sentrix made a good faith effort to notify the carrier of their failure to respond to the bill on 7/11/16 and it was received by the provided on 7/14/16 … Again, no action was taken on the claim."

**Amount in Dispute:** $2,568.98

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "ODG guidelines do not recommend the use of custom compounded combinations of medications that have never been studied. There is no evidence that this particular combination of medications has been studied for efficacy. Moreover, there are multiple ingredients that are not supported by ODG for topical use. The claimant was provided this compounded cream on 4/25/16 but there is no indication of objective clinical benefit in the notes available for review. Medical necessity of the reviewed medication is not established."

**Response Submitted by:** The Hartford

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| May 20, 2016 | Pharmacy Services - Compound | $2,568.98 | $2,568.98 |

## *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 §134.502 sets out the procedures for pharmaceutical services.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 71 – Prescriber is not covered.

**Issues**

1. Did Sentinel Insurance Company, Ltd. (Sentinel) raise an issue of medical necessity in accordance with 28 Texas Administrative Code §133.307?
2. Is Sentinel's reason for denial of payment supported?
3. Is Sentrix Pharmacy and Discount, L.L.C. (Sentrix) entitled to reimbursement for the disputed service?

**Findings**

1. Sentrix is seeking reimbursement of $2,568.98 for a compound cream dispensed on May 20, 2016. In its position statement, The Hartford, on behalf of Sentinel, stated, "Medical necessity of the reviewed medication is not established." 28 Texas Administrative Code §133.307(d)(2)(F) states:

   > The [carrier's] 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 no evidence that an issue of medical necessity was presented to Sentrix prior to the date the request for medical fee dispute resolution was filed with the division. The division concludes that the defense relating to medical necessity presented in The Hartford's position statement shall not be considered for review because those assertions constitute new defenses pursuant to 28 Texas Administrative Code §133.307(d)(2)(F).

2. Per the remittance advice dated June 4, 2016, Sentinel denied the disputed compound with claim adjustment code 71 – "PRESCRIBER IS NOT COVERED." Review of available information failed to support Sentinel's denial. The services will be reviewed in accordance with applicable fee guidelines.

3. 28 Texas Administrative Code §134.503 applies to the compound in dispute and states, in pertinent 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 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; or
         (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

   The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately as required by 28 Texas Administrative Code §134.502(d)(2). Each ingredient is listed below with its corresponding reimbursement amount as applicable.

| Ingredient | NDC & Type | Price/ Unit | Total Units | AWP Formula §134.503(c)(1) | Billed Amt §134.503 (c)(2) | Lesser of (c)(1) and (c)(2) |
|---|---|---|---|---|---|---|
| Salt Stable Cream Base | 00395602157 Brand Name | $3.36 | 145.92 gm | $3.36 x 145.92 x 1.09 = $534.42 | $490.29 | $490.29 |
| Baclofen 4% | 38779038808 Generic | $35.63 | 9.6 gm | $35.63 x 9.6 x 1.25 = $427.56 | $342.05 | $342.05 |
| Amantadine 8% | 38779041109 Generic | $24.225 | 19.2 gm | $24.225 x 19.2 x 1.25 = $581.40 | $465.12 | $465.12 |
| Clonidine 0.2% | 38779056105 Generic | $206.625 | 0.48 gm | $206.625 x 0.48 x 1.25 = $123.98 | $93.48 | $93.48 |
| Dimethyl Sulfoxide | 38779061409 Generic | $1.24 | 12 ml | $1.24 x 12 x 1.25 = $18.60 | $14.88 | $14.88 |
| Amitriptyline 2% | 58597800308 Generic | $19.15 | 4.8 gm | $19.15 x 4.8 x 1.25 = $114.90 | $91.92 | $91.92 |
| Gabapentin 5% | 58597801407 Generic | $62.84 | 12 gm | $62.84 x 12 x 1.25 = $942.60 | $754.08 | $754.08 |
| Ketoprofen 10% | 58597801707 Generic | $10.97 | 24 gm | $10.97 x 24 x 1.25 = $329.10 | $263.28 | $263.28 |
| Lidocaine 5% | 58597802007 Generic | $4.49 | 12 gm | $4.49 x 12 x 1.25 = $67.35 | $53.88 | $53.88 |
| | | | | | Total | $2,568.98 |

The total allowable reimbursement is $2,568.98. 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 $2,568.98.

## *ORDER*

Based on the submitted information, pursuant to Texas Labor Code Sec. 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 $2,568.98, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| | Laurie Garnes | May 10, 2017 |
|---|---|---|
| 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**.