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, LLC

Respondent Name
Zurich American Insurance Company

MFDR Tracking Number
M4-17-2710-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 15, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… the Carrier apparently seeks documentation to support the use of the medication in topical form. Albeit not statutorily required for the compensation of workers' compensation benefits, Sentrix has attached supporting documentation hereto for the purposes of facilitating the processing of the subject claim."

Amount in Dispute: $2,078.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier denied payment as the initial claim and subsequent submissions from the Requestor lacked information and documentation necessary for proper review of the bill for this 'Transdermal Pain Cream'. The relatedness, appropriateness and medical necessity of the cream (and its individual components) to the compensable injury could not be determine from Requestor's submission."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 9, 2017	Pharmacy Service – Compound	$2,078.06	$1,718.06

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 §133.10 sets out the requirements for a complete pharmacy bill.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Did Zurich American Insurance Company (Zurich) raise a new defense in its position statement?
2. Is the Zurich's reason for denial of payment supported?
3. Is Sentrix Pharmacy and Discount, L.L.C. (Sentrix) entitled to reimbursement of the disputed compound?

Findings

1. Sentrix is seeking reimbursement for a compound dispensed on January 9, 2017. In its position statement, Flahive, Ogden & Latson argued on behalf of the insurance carrier, "The relatedness, appropriateness and medical necessity of the cream (and its individual components) to the compensable injury could not be determine from Requestor's submission."

   The insurance carrier is required to address only those issues raised before the request for medical fee dispute resolution (MFDR) in its position statement.[1]

   Review of the submitted documentation finds that Zurich failed to present a denial based on relatedness or medical necessity to Sentrix[2] before the date that a request for MFDR was filed.

   The division concludes that this defense presented in the insurance carrier's position statement shall not be considered for review because this assertion constitutes a new defense.

2. Zurich denied the disputed compound with claim adjustment reason code 16 – "CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION."

   Review of the submitted pharmacy bills finds no submission or billing errors.[3] Flahive, Ogden & Latson failed to support this denial in its position statement.

3. Because the insurance carrier's denial reasons are not supported, the compound in question is eligible for reimbursement in accordance with applicable rules and laws.

   The compound in question was submitted with the following ingredients:

   - Salt Stable LS Base, NDC 00395602157, $572.54
   - Baclofen, NDC 00395803243, $342.05
   - Amitriptyline, NDC 00395804843, $87.55
   - Ketoprofen, NDC 00395805643, $250.80
   - Amantadine, NDC 00395805843, $465.12
   - Gabapentin, NDC 10695003507, $360.00

   The division finds that NDC 10695003507 is not a valid National Drug Code (NDC).[4] Therefore, this ingredient will not be considered for reimbursement.

   The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately.[5] Each ingredient is listed below with its reimbursement amount.[6] The calculation of the total allowable amount is as follows:

[1] 28 Texas Administrative Code §133.307(d)(2)(F)
[2] 28 Texas Administrative Code §133.240
[3] 28 Texas Administrative Code §133.10(f)(3)
[4] 28 Texas Administrative Code §134.502(d)(1)
[5] 28 Texas Administrative Code §134.502(d)(2)
[6] 28 Texas Administrative Code §134.503(c)

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Salt Stable Base	00395602157	B	$3.36	170.4	$624.07	$572.54	$572.54
Baclofen	00395803243	G	$35.63	9.6	$427.56	$342.05	$342.05
Amitriptyline	00395804843	G	$18.24	4.8	$109.44	$87.55	$87.55
Ketoprofen	00395805643	G	$10.45	24	$313.50	$250.80	$250.80
Amantadine	00395805843	G	$24.23	19.2	$581.40	$465.12	$465.12
Gabapentin	Invalid NDC	NA	NA	12	$0.00	$360.00	$0.00
						Total	$1,718.06

The total allowable reimbursement for the compound in dispute is $1,718.06. 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 $1,718.06.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $1,718.06, 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	August 2, 2018 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 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. **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.