



# 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 and Discount, L.L.C.

**Respondent Name**

Lockheed Martin Corporation

**MFDR Tracking Number**

M4-17-2822-01

**Carrier's Austin Representative**

Box Number 60

**MFDR Date Received**

May 22, 2017

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "28 TAC §134.530 clearly states that preauthorization is only required for any compound that contains a drug identified with a status of 'N' in the current edition of the ODG Workers' Compensation Drug Formulary. In the case of the claim(s) as issue, all of the ingredients are identified with a 'Y' in the July 2016 Drug Formulary or not listed at all. As demonstrated by the enclosed documentation, all ingredients in the compounded medications subject to the claims at issue are included on the closed formulary."

**Amount in Dispute:** \$2,488.99

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** Submitted documentation does not include a position statement from the respondent for the dispute in question. Accordingly, this decision is based on the information available at the time of review.

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 5, 2016	Pharmacy Services - Compounds	\$2,488.99	\$1,668.62

### 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 benefits.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. 28 Texas Administrative Code §134.540 sets out the closed formulary requirements for claims subject to certified networks.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 197 – Precertification/authorization/notification absent.
  - Notes: “COMPOUND BILLING GABAPENTIN REQUIRING PRE-AUTH”
  - Notes: “PART OF COMPOUND PRESC W/ DRUG REQUIRING PRE-AUTH”
  - X141 – Payment disallowed: Lack of authorization: No authorization given for services rendered.

### Issues

1. Did the insurance carrier respond to the medical fee dispute?
2. Is the insurance carrier’s reason for denial of payment supported?
3. Is Sentrix Pharmacy and Discount, L.L.C. (Sentrix) entitled to reimbursement for the compound in question?

### Findings

1. The Austin carrier representative for Lockheed Martin Corporation (Lockheed Martin) is Downs-Stanford, P.C. Downs-Stanford, P.C. acknowledged receipt of the copy of this medical fee dispute on May 31, 2017. 28 Texas Administrative Code §133.307 states, in relevant part:

(d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.

- (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

Review of the documentation finds that no response has been received on behalf of Lockheed Martin from Downs-Stanford, P.C. to date. The division concludes that Lockheed Martin failed to respond within the timeframe required by §133.307(d)(1). For that reason the division will base its decision on the information available.

2. Sentrix is seeking reimbursement of \$2,488.99 for a compound dispensed on July 5, 2016. Lockheed Martin denied the disputed compound with claim adjustment reason codes 197 – “PERCERTIFICATION /AUTHORIZATION/NOTIFICATION ABSENT,” and X141 – “PAYMENT DISALLOWED: LACK OF AUTHORIZATION: NO AUTHORIZATION GIVEN FOR SERVICES RENDERED.”

28 Texas Administrative Code §134.540(b) states that preauthorization is **only** required for:

- 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;
- 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
- 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 the compound in question does not include a drug identified with a status of “N” in the current edition of the ODG, *Appendix A*. Lockheed Martin failed to articulate any arguments to support its denial for preauthorization. Therefore, the division concludes that the compound in question did not require preauthorization and Lockheed Martin’s denial of payment for this reason is not supported. Therefore, the disputed compound will be reviewed for reimbursement.

3. Sentrix is seeking reimbursement for a compound billed with the following ingredients:
  - Salt Stable LS Base, NDC 00395602157, \$572.47
  - Baclofen 4%, NDC 38779038808, \$341.99
  - Amantadine 8%, NDC 38779011109, \$465.19

- Amitriptyline 2%, NDC 5897800308, \$91.84
- Gabapentin 5%, NDC 58597801407, \$754.16
- Ketoprofen 10%, NDC 5897801707, \$263.34

The division finds that NDC 38779011109 as billed for Amantadine 8% is not a valid National Drug Code (NDC) for this ingredient, as required by 28 Texas Administrative Code §134.502(d)(1). Therefore, this ingredient will not be considered for reimbursement.

The division finds that NDC 5897800308 as billed for Amitriptyline 2% is not a valid NDC as required by 28 Texas Administrative Code §134.502(d)(1). Therefore, this ingredient will not be considered for reimbursement.

The division finds that NDC 5897801707 is not a valid NDC as required by 28 Texas Administrative Code §134.502(d)(1). Therefore, this ingredient will not be considered for reimbursement.

28 Texas Administrative Code §134.503 applies to the compounds 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:  $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.25) + \$4.00$  dispensing fee per prescription = reimbursement amount;
    - (B) Brand name drugs:  $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.09) + \$4.00$  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)
Compound Fee	NA	\$15.00	NA	\$15.00	\$0.00	\$0.00
Salt Stable LS Base	00395602157 Brand Name	\$3.36	170.4 gm	\$624.07	\$572.47	\$572.47
Baclofen 4%	38779038808 Generic	\$35.63	9.6 gm	\$427.56	\$341.99	\$341.99
Amantadine 8%	38779011109 Invalid NDC	\$0.00	19.2 gm	\$0.00	\$465.19	\$0.00
Amitriptyline 2%	5897800308 Invalid NDC	\$0.00	4.8 gm	\$0.00	\$91.84	\$0.00
Gabapentin 5%	58597801407 Generic	\$62.84	12.0 gm	\$942.60	\$754.16	\$754.16
Ketoprofen 10%	5897801707 Invalid NDC	\$0.00	24.0 gm	\$0.00	\$263.34	\$0.00
					Total	\$1,668.62

The total reimbursement is therefore \$1,668.62. 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 \$1,668.62.

***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 \$1,668.62, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

_____	Laurie Garnes	January 10, 2018
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 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.**