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

Respondent Name
Sunz Insurance Company

MFDR Tracking Number
M4-17-3204-01

Carrier's Austin Representative
Box Number 20

MFDR Date Received
July 3, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Sentrix submitted an itemized bill for each of the drugs including the quantity and the charges based on fair and reasonable reimbursement pursuant to §134.1(e)(3) of Section 28 of the Texas Administrative Code."

Amount in Dispute: $11,022.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor cannot demonstrate the necessity of the mediations for which they claim reimbursement…"

Response Submitted by: Lewis & Backhaus, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 18, 2017	Pharmacy Service – Compound	$11,022.68	$11,022.68

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 §133.240 sets out the procedures for payment or denial of a medical bill.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. 28 Texas Administrative Code Chapter 19 sets out the procedures for utilization review.
5. Texas Insurance Code, Chapter 4201 provides requirements related to utilization review.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

- Note: “not reasonable nor necessary”

Issues

1. Is the insurance carrier’s denial of payment for medical necessity supported?
2. Is Sentrix Pharmacy and Discount, L.L.C. (Sentrix) entitled to reimbursement of the disputed services?

Findings

1. Sentrix is seeking reimbursement of $11,022.68 for a compound dispensed on April 18, 2017, consisting of the following ingredients:

Compound Cream in Dispute	
Ingredient	Amount
Sanare Gel	214.8 gm
Propylene Glycol	14.4 ml
Pentoxifylline 0.5%	1.2 gm
Tranilast 1%	2.4 gm
Fluticasone Propionate 1%	2.4 gm
Levocetirizine Dihydrochloride 2%	4.8 gm

Sunz Insurance Company (Sunz) denied the disputed compound, in part, stating, “not reasonable nor necessary.” Texas Administrative Code §133.240(q) states:

> When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title … Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title …, including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor, respectively.

Review of the documentation submitted by Lewis & Backhaus, P.C. on behalf of Sunz finds a document labeled “Addendum” and dated August 5, 2017. The division finds that the submitted documentation does not support that retrospective utilization review of the compound in question was conducted with the specificity required by 28 Texas Administrative Code §19.2009 prior to the request for medical fee dispute. Therefore, the review was not conducted in accordance 28 Texas Administrative Code §133.240. Sunz’ denial for this reason is not sufficiently supported.

2. Sunz also denied the disputed compound, in part, with claim adjustment reason code P12 – “Workers’ compensation jurisdictional fee schedule adjustment.” 28 Texas Administrative Code §134.503 applies to the fees for the services 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). Reimbursement is calculated as follows:

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)
Propylene Glycol	00395232728 Generic	$0.20211	14.4 ml	$3.64	$2.92	$2.92
Sanare Gel	00395701159 Generic	$12.15	214.8 gm	$3,262.28	$2,609.82	$2,609.82
Fluticasone Propionate 1%	00395805419 Generic	$3,449.3552	2.4 gm	$10,348.07	$8,278.45	$8,278.45
Levocetirizine Dihydrochloride 2%	51552141505 Generic	$82.60	4.8 gm	$495.60	$101.43	$101.43
Tranilast 1%	51927317800 Generic	$10.93	2.4 gm	$32.79	$25.20	$25.20
Pentoxifylline 0.5%	62991252101 Generic	$4.05	1.2 gm	$6.08	$4.86	$4.86
NA	NA	NA	NA	$15.00 fee	$0.00	$0.00
					Total	$11,022.68

The total allowable reimbursement for the compound in dispute is $11,022.68. 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 $11,022.68.

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 $11,022.68, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	December 21, 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 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.