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
American Specialty Pharmacy

Respondent Name
Travelers Indemnity Company of Connecticut

MFDR Tracking Number
M4-15-2937-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
May 11, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This treatment is necessary to achieve a therapeutic outcome… This medication is medically necessary in order to decrease pain, reduce the need for narcotics and/or other prescription analgesics and to preserve function of the patient."

Amount in Dispute: $1612.95

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Rule 134.530(b)(1)(C) requires preauthorization for '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 Sect. 413.014(a).' By compounding multiple ingredients into a single applied cream, the Provider has created a new drug which the Federal Drug Administration has not recognized or approved… As this compound is therefore investigational or experimental, it required preauthorization under Rule 134.503(b)(1)(C). The Provider did not request or obtain preauthorization prior to providing this prescription. Therefore, the Provider is not entitled to reimbursement for the disputed services."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 4, 2014	Prescription Medication (Compound Cream)	$1612.95	$1612.95

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 §134.500 provides definitions for terms relevant to pharmaceutical benefits.
3. 28 Texas Administrative Code §134.503 sets out the guidelines for billing and reimbursing pharmaceutical benefits.
4. 28 Texas Administrative Code §134.540 sets out the guidelines for use of the closed formulary 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.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code "197 – Precertification/authorization/notification absent." 28 Texas Administrative Code §134.500 defines the closed formulary as,

   (3) All available Food and Drug Administration (FDA) approved prescription and nonprescription drugs prescribed and dispensed for outpatient use, but excludes:
   (A) drugs identified with a status of "N" in the current edition of the *Official Disability Guidlines Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates;
   (B) 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
   (C) 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).

   Further, 28 Texas Administrative Code §134.540 states, in relevant part,

   (b) Preauthorization for claims subject to the Division's closed formulary. Preauthorization is only required for: …
   (2) 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."

   Review of the submitted documentation finds that the dispute involves a compound drug that includes the ingredients Flurbiprofen, Cyclobenzaprine, Baclofen, Ethoxy Diglycol, Propylene Glycol, and Versapro Cream. The FDA has approved the listed ingredients. The *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary* in effect on the date of service finds that the compound in dispute does not include an "N" status drug. Therefore, preauthorization was not required. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. The MAR in for the disputed services is established by the AWP formula pursuant to 28 Texas Administrative Code §134.503 (c), which states, in relevant 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

The requestor is seeking reimbursement for the generic compound ingredients Flurbiprofen, 30 gm, NDC 38779273909; Cyclobenzaprine, 3 gm, NDC 38779039503; Baclofen, 3 gm, NDC 38779038805; Ethoxy Diglycol, 15 ml, NDC 38779190301; Propylene Glycol, 15 ml, NDC 38779051001; and the brand name compound ingredient Versapro Cream, 84 gm, NDC 38779252903. The disputed medications were dispensed on December 4, 2014. The MAR 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	MAR
12/4/14	Flurbiprofen, 30 gm	(36.58 x 30 x 1.25) + $4.00 = $1375.75	$1097.40	$1097.40	$0.00	$1097.40
12/4/14	Cyclobenzaprine, 3 gm	(46.33 x 3 x 1.25) + $4.00 = $177.75	$133.95	$133.95	$0.00	$133.95
12/4/14	Baclofen, 3 gm	(35.63 x 3 x 1.25) + $4.00 = 137.61	$102.60	$102.60	$0.00	$102.60
12/4/14	Ethoxy Diglycol, 15 ml	(.34 x 15 x 1.25) + $4.00 = $10.41	$7.35	$7.35	$0.00	$7.35
12/4/14	Propylene Glycol, 15 ml	(.19 x 15 x 1.25) + $4.00 = $7.56	$2.85	$2.85	$0.00	$2.85
12/4/14	Versapro Cream, 84 gm	(3.20 x 84 x 1.09) +$4.00 = $296.99	$268.80	$268.80	$0.00	$268.80
Compounding Fee		$15.00	$0.00	$0.00	$0.00	$0.00

3. The total MAR for the disputed services is $1612.95. The insurance carrier paid $0.00. A reimbursement of $1612.95 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 $1612.95.

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 involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1612.95 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	September 1, 2015 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.