



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

Property & Casualty Insurance Company of Hartford

MFDR Tracking Number

M4-17-2708-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

May 15, 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 December 2016 Drug Formulary. 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: \$2,078.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our investigation shows the following:

- NDC 10695003507, Gabapentin 5%, one of the ingredients, is an invalid NDC.
- Denial issued by ESI as incomplete...

The Hartford respectfully does not recommend approval for the requested services of compound medication ... as reasonable or medically necessary. This CMPD was denied per Peer Review 1/19/17..."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 9, 2016	Pharmacy Services - Compounds	\$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 §133.307 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 §134.502 sets out the procedures for pharmaceutical benefits.
4. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
5. 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to certified networks.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - M123 – Prescription is incomplete
 - 197 – Precertification/authorization/notification absent

Issues

1. Did Property & Casualty Insurance Company of Hartford (Hartford) raise a medical necessity issue in accordance with 28 Texas Administrative Code §133.307?
2. Is Hartford’s denial of payment for an incomplete prescription supported?
3. Is Hartford’s denial of payment for preauthorization supported?
4. Is Sentrix Pharmacy and Discount (Sentrix) entitled to reimbursement for the compound in question?

Findings

1. In its position statement, Hartford argued that it “does not recommend approval for the requested services of compound medication ... as reasonable or medically necessary. This CMPD was denied per Peer Review 1/19/17.”

28 Texas Administrative Code §133.307(d)(2)(F) states, in relevant part, “The 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 does not find that Hartford presented a medical necessity denial in accordance with 28 Texas Administrative Code §133.240 as a reason for denial of payment to Sentrix prior to the date the request for medical fee dispute resolution (MFDR) was filed. The division concludes that this defense presented in Hartford’s position statement shall not be considered for review because this assertion constitutes a new defense pursuant to 28 Texas Administrative Code §133.307(d)(2)(F).

2. Sentrix is seeking reimbursement of \$2,078.06 for a compound dispensed on December 9, 2016, with the following ingredients:

Compound Cream in Dispute	
Ingredient	Amount
Salt Stable LS Base	170.4 gm
Baclofen 4%	9.6 gm
Amitriptyline 2%	4.8 gm
Ketoprofen 10%	24.0 gm
Amantadine 8%	19.2 gm
Gabapentin 5%	12.0 gm

Hartford denied the disputed compound in part with claim adjustment reason code M123 – “Prescription is incomplete.” Review of the submitted documentation finds a prescription signed by Dr. John A. Ribiero’s physician’s assistant on November 10, 2016, that corresponds to the compound in question. Hartford’s denial for this reason is not supported.

3. Hartford denied the disputed compound in part with claim adjustment reason code 197 – “Precertification/authorization/notification absent.”

28 Texas Administrative Code §134.530(b)(2) 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*. Hartford failed to articulate any arguments to support its denial for preauthorization. For this reason, the division concludes that the compound in question did not require preauthorization and Hartford's denial of payment for this reason is not supported. Therefore, the disputed compound will be reviewed for reimbursement.

4. Sentrix is seeking reimbursement for a compound submitted as follows:

- Salt Stable LS Base, NDC 00395602157, \$572.54
- Baclofen 4%, NDC 00395803243, \$342.05
- Amitriptylline 2%, NDC 00395804843, \$87.55
- Ketoprofen 10%, NDC 00395805643, \$250.80
- Amantadine 8%, NDC 00395805843, \$465.12
- Gabapentin 5%, NDC 10695003507, \$360.00

The division finds that NDC 10695003507 is not a valid National Drug Code (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: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;
 - (B) Brand name drugs: $((\text{AWP 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)
Salt Stable LS Base	00395602157 Brand Name	\$3.36	170.4 gm	\$624.07	\$572.54	\$572.54
Baclofen 4%	00395803243 Generic	\$35.63	9.6 gm	\$427.56	\$342.05	\$342.05

Amitriptyline 2%	00395804843 Generic	\$18.24	4.8 gm	\$109.44	\$87.55	\$87.55
Ketoprofen 10%	00395805643 Generic	\$10.45	24.0 gm	\$313.50	\$250.80	\$250.80
Amantadine 8%	00395805843 Generic	\$24.225	19.2 gm	\$581.40	\$465.12	\$465.12
Gabapentin 5%	10695003507 Invalid NDC	\$0.00	12.0 gm	\$0.00	\$360.00	\$0.00
Compound Fee	NA	\$0.00	NA	\$15.00	\$0.00	\$0.00
					Total	\$1,718.06

The total reimbursement is therefore \$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

December 1, 2017

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.