



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

Indemnity Insurance Company of North America

MFDR Tracking Number

M4-17-2718-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

May 15, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The insurance carrier, Broadspire, failed to take final action on the claim within the 45-day period set forth in TAC §133.240. Specifically the claim was submitted on 2/6/17 and it was received by the provider on 2/13/17 ... and no action was taken on the claim. The Pharmacy had submitted a second request for payment (on 4/11/17) ... and it was received by the provider on 4/18/17 ... Again, no action was taken on the claim."

Amount in Dispute: \$2,078.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment is disputed as the medications were not preauthorized."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 6, 2017	Pharmacy Services - 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 §133.307 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 §134.530 sets out the closed formulary requirements for claims not subject to certified networks.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- 39 – Denied – Medication Not Authorized

Issues

1. Is Indemnity Insurance Company of North America’s denial of payment for the disputed service supported?
2. Is Sentrix Pharmacy and Discount, L.L.C. (Sentrix) entitled to reimbursement for the compound in dispute?

Findings

1. Sentrix is seeking reimbursement of \$2,078.06 for a compound cream dispensed on February 6, 2017. Indemnity Insurance Company of North America denied the disputed service with claim adjustment reason code 39 – “Denied – Medication Not Authorized.” Indemnity Insurance Company of North America did not specify a basis for its assertion that the compound in question required authorization. 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).

Indemnity Insurance Company of North America failed to articulate any defenses for denial of the disputed compound for preauthorization. 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*. Therefore, the division concludes that the compound in question did not require preauthorization and Indemnity Insurance Company of North America’s denial for this reason is not supported.

2. Sentrix is seeking reimbursement for a compound dispensed on February 6, 2017, with the following ingredients:
 - Salt Stable LS Base, NDC 00395602157, \$572.54
 - Baclofen 4%, NDC 00395803243, \$342.05
 - Amitriptyline 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 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: $((\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).

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)
Salt Stable LS Base	00395602157 Brand Name	\$3.36	170.4 gm	$\$3.36 \times 170.4 \times 1.09 = \624.07	\$572.54	\$572.54
Baclofen 4%	00395803243 Generic	\$35.63	9.6 gm	$\$35.63 \times 9.6 \times 1.25 = \427.56	\$342.05	\$342.05
Amitriptyline 2%	00395804843 Generic	\$18.24	4.8 gm	$\$18.24 \times 4.8 \times 1.25 = \109.44	\$87.55	\$87.55
Ketoprofen 10%	00395805643 Generic	\$10.45	24.0 gm	$\$10.45 \times 24 \times 1.25 = \313.50	\$250.80	\$250.80
Amantadine 8%	00395805843 Generic	\$24.225	19.2 gm	$\$24.225 \times 19.2 \times 1.25 = \581.40	\$465.12	\$465.12
Total					\$1,718.06	\$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	July 19, 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.