

TITLE 28. INSURANCE

**PART 2. TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION**

**CHAPTER 134. BENEFITS--GUIDELINES FOR MEDICAL
SERVICES, CHARGES, AND PAYMENTS**

**SUBCHAPTER F - PHARMACEUTICAL BENEFITS
28 TAC §134.503 and §134.504**

1. INTRODUCTION.

The Commissioner of Workers' Compensation (Commissioner), Texas Department of Insurance, Division of Workers' Compensation (Division) adopts amendments to §134.503 (relating to Pharmacy Fee Guideline), with corresponding amendments to §134.504 (relating to Pharmaceutical Expenses Incurred by the Injured Employee). The amendments to §134.503 are adopted with changes to the proposed text as published in the July 1, 2011, issue of the *Texas Register* (36 TexReg 4092). The Division adopts the amendments to §134.504 without changes to the proposed text and the section will not be republished.

In accordance with Government Code §2001.033, the Division's reasoned justification for these amendments is set out in this order, which includes the preamble, which in turn includes the rules. The reasoned justification is contained throughout the preamble, including the reasons why the amended rules are necessary; the factual, policy and legal bases for the amended rules; a summary of comments received from interested parties, names of the entities that commented and whether they were in support of or in opposition to the adoption of the rules, and the reasons why the Division agrees or disagrees with the comments and recommendations.

The Commissioner conducted a public hearing on the proposed amendments on July 11, 2011. Three individuals provided public testimony at this hearing. The public comment period for

these proposed amended rules ended on August 1, 2011. The Division received eight written public comments.

2. REASONED JUSTIFICATION.

The rule revisions to §134.503 and §134.504 are necessary to adopt a pharmacy fee guideline and to implement new Labor Code §408.0281 and other legislative amendments in House Bill 528, enacted by the 82nd Legislature, Regular Session, effective June 17, 2011 (HB 528), that impact the reimbursement of pharmacy and pharmaceutical services provided in the Texas workers' compensation system. Section 134.504 is also amended and governs pharmaceutical expenses incurred by an injured employee when the injured employee elects to receive a brand name drug rather than a generic drug or over-the-counter alternative to a prescription medication that is prescribed by a health care provider. The amendments to this rule conform references to §134.503. The Division made changes to the proposed text based on public comments. Specifically, changes were made to §134.503(c)(1)(A) and (B) and §134.503(c)(2) as described in the "Summary of Comments and Agency Responses." The Division also made other nonsubstantive changes for purposes of clarity. These changes do not materially alter issues raised in the proposal, introduce new subject matter, or affect persons, other than those previously on notice.

Labor Code §408.028(f) requires the Commissioner by rule to adopt a pharmacy fee guideline for pharmacy and pharmaceutical services. It also sets out the criteria for the fee guideline. Labor Code §408.028(f) was originally enacted by House Bill 7, 79th Legislature, Regular Session, effective September 1, 2005 (HB 7), and recently amended by HB 528. As originally enacted by HB 7, Labor Code §408.028(f) required the Commissioner, notwithstanding any other provision in Title 5 of the Labor Code, to adopt a fee schedule for pharmacy and pharmaceutical services that will: (1) provide reimbursement rates that are fair and reasonable; (2) assure adequate access to medications and

services for injured employees; and (3) minimize costs to employees and insurance carriers. HB 528 amended Labor Code §408.028(f) by adding an additional criteria that the pharmacy fee guideline adopted by the Commissioner must take into consideration the increased security of payment afforded by the Texas Workers' Compensation Act (Act).

In addition to enacting Labor Code §408.028(f), HB 7 also enacted Labor Code §408.028(g). This statute provided that "insurance carriers must reimburse for pharmacy benefits and services using the fee schedule as developed by [Labor Code §408.028], or at rates negotiated by contract." HB 528 amended subsection (g) by deleting the above described text and replacing it with provisions that state, "[s]ection 413.011(d) and the rules adopted to implement that subsection do not apply to the fee schedule adopted by the commissioner under [Labor Code §408.028(f)]."

Labor Code §413.011(d) sets out criteria for fee guidelines, one of which states that the guidelines "may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf." This provision has been interpreted as the statutory justification for "usual and customary charge for the same or similar service" language that was present in the previous pharmacy reimbursement methodology. Therefore, the Division interprets the removal of Labor Code §413.011(d) from the pharmacy fee guideline considerations as legislative intent to remove the "usual and customary charge for the same or similar service" element from the reimbursement methodology. This interpretation is supported by a statement of legislative intent for HB 528, which states that the "usual and customary charge" element of the previous pharmacy reimbursement methodology was extremely costly to the overall system. The goal of the amendment according to this statement of legislative intent was to provide clarity as to the reimbursement price and to reduce disputes over the reimbursements for pharmaceutical services.

HB 528 also amended Labor Code Chapter 408, Subchapter B, by adding §408.0281 (relating to Reimbursement for Pharmaceutical Services; Administrative Violation). Labor Code §408.0281(b)(1) states that notwithstanding any provision of Chapter 1305, Insurance Code, or §504.053, Labor Code, prescription medication or services, as defined by §401.011(19)(E), may be reimbursed in accordance with the fee guidelines adopted by the Commissioner or at a contract rate in accordance with this section.

As stated, Labor Code §408.0281(b)(1) authorizes the reimbursement for prescription medication or services at a contract rate in accordance with Labor Code §408.0281. Under Labor Code §408.0281(c), an insurance carrier may pay a health care provider fees for pharmaceutical services that are inconsistent with fee guidelines adopted by the Commissioner only if the insurance carrier has a contract with the health care provider and that contract includes a specific fee schedule. An insurance carrier, or the carrier's authorized agent, may use an informal or voluntary network to obtain a contractual agreement that provides for fees different from the fees authorized under the fee guidelines adopted by the Commissioner for pharmaceutical services. If the carrier or the carrier's authorized agent chooses to use an informal or voluntary network to obtain a contractual fee arrangement, Labor Code §408.0281(c)(1) and (2) requires there to be a contractual arrangement between: (1) the carrier or its authorized agent and the informal or voluntary network that authorizes the network to contract with health care providers for pharmaceutical services on the carrier's behalf; and (2) the informal or voluntary network and the health care provider that includes a specific fee schedule and complies with the notice requirements in Labor Code §408.0281. The notice requirements in Labor Code §408.0281 generally require the informal or voluntary network, or the carrier or carrier's authorized agent, to notify each health care provider of any person, other than

the injured employee, to which the network's contractual fee arrangements with that health care provider are sold, leased, transferred, or conveyed.

Finally, Labor Code §408.0281(b)(2) prohibits the delivery of prescription medication or services through a certified workers' compensation health care network under the Insurance Code Chapter 1305, or through a contract described by Labor Code §504.053(b)(2). HB 528 also amended Insurance Code §1305.101(c), which now provides that notwithstanding any other provisions of [Insurance Code Chapter 1305], prescription medication or services, as defined by Labor Code §401.011(19)(E), may not directly, or through a contract, be delivered through a certified workers' compensation health care network. Prescription medication and services shall be reimbursed pursuant to Labor Code §408.0281, other provisions of the Act, and applicable rules of the Commissioner.

The Division sought professional expertise during this rulemaking project and engaged with its system participants to obtain meaningful input. The Division contracted with Milliman, Inc. to evaluate pharmaceutical reimbursement levels under the Texas workers' compensation system and compare them to rates paid in other markets. This resulted in the Milliman Inc. report entitled, *Pharmaceutical Reimbursement Comparison Report: Indexing of Texas Workers' Compensation Pharmaceutical Reimbursement and Comparison to Other Healthcare Markets, October 22, 2009* (Milliman Report). The Division held two stakeholder meetings to obtain input on issues relating to the pharmacy fee guideline such as the appropriate benchmark for the pharmacy fee guideline. The Division also posted on its website informal drafts representing two alternatives of the pharmacy fee guideline and requested system participants to provide comments on these drafts. The Division also consulted with its Medical Advisor who provided medical expertise and input.

Amended §134.503 will govern the reimbursement for all outpatient pharmacy and pharmaceutical services, excluding parenteral drugs, provided to injured employees in the Texas workers' compensation system. The inpatient drug and parenteral drug exclusions are continuations from the previous §134.503. Consistent with Labor Code §408.0281(b), this rule will apply to pharmacy and pharmaceutical reimbursements regardless of whether the injured employee is subject to a workers' compensation health care network certified under Chapter 1305 of the Insurance Code; is receiving medical benefits in accordance with Chapter 408 of the Labor Code; or is receiving medical benefits in accordance with Labor Code §504.053(b)(2). HB 528 and its requirements became effective on June 17, 2011. The application of this amended rule is prospective and will apply to the reimbursement of prescription drugs and nonprescription drugs or over-the-counter medications that are dispensed on or after the effective date of the amendments to this rule.

Section 134.503(c) is the pharmacy fee guideline for prescription drugs. The Division has determined that the adopted pharmacy fee guideline for prescription drugs located in §134.503(c)(1) - (2) of this adopted rule meets the statutory requirements imposed upon the Division by Labor Code §408.028(f). Specifically, the Division has determined that the reimbursement under §134.503(c) will: (1) provide reimbursement rates for prescription drugs that are fair and reasonable; (2) assure adequate access to prescription medications and services for injured employees; (3) minimize costs to injured employees and insurance carriers; and (4) take into consideration the increased security of payment afforded by the Act.

The Division's adopted pharmacy fee guideline for prescription drugs is fair and reasonable for several reasons. First, it deletes "usual and customary" from its pharmacy fee guideline and replaces it with "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 health care provider or 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.” This change ensures that reimbursement rates still account for pharmacy billing practices, if the billed amount is less than the amount provided by the applicable formula in §134.503(c)(1). Furthermore, as set forth more fully below, this provides an objective standard that can easily be determined on a case-by-case basis and, therefore should lead to increased system participant clarity regarding their entitlements and obligations under the adopted pharmacy fee guideline, which will decrease fee disputes.

Second, the Division’s adopted pharmacy fee guideline for prescription drugs is fair and reasonable because it retains the same reimbursement formulas that have been in §134.503 since 2002 and it ensures market stability while the Division implements other statutorily required changes. The Division is already, pursuant to HB 528, making one change to pharmacy reimbursement, replacing “usual and customary” with “amount billed,” and this change is in addition to the new administrative requirements regarding informal and voluntary network contracts for prescription drugs and services. Furthermore, the Division’s pharmacy closed formulary, a series of rules in 28 Texas Administrative Code (TAC) Chapter 134, Subchapter F, came into effect for new injuries on or after September 1, 2011 and will likely have an impact on services in the Texas workers’ compensation system. The Division, therefore, has elected to retain its current reimbursement formula under §134.503(c)(1) in order to ease the impacts caused by these statutorily-required changes for system participants. Additionally, retaining the same reimbursement formula permits the Division to observe the system impacts of the aforementioned other statutorily required changes and gather full information before deciding to possibly change its reimbursement formula.

Lastly, the Division's adopted pharmacy fee guideline for prescription drugs is fair and reasonable because the reimbursements ensure that Texas remains typical of workers' compensation reimbursement for prescription drugs in other states. Specifically, the Milliman Report indicated that even though Texas workers' compensation reimbursement is above that seen in other health care markets, the Texas fee schedule was typical of workers' compensation fee schedules in other states. Furthermore, in reviewing other states' workers' compensation fee schedules, the Workers' Compensation Research Institute (WCRI) report, *Workers' Compensation Medical Cost Containment: A National Inventory*, January 2011, reflects a range of 84% to 140% of average wholesale price (AWP) for brand name drugs and a range of 75% to 140% of AWP for generic drugs. Dispensing fees ranged from \$2.00 to \$10.67. The Division, by retaining its reimbursement formula of 109% of AWP for brand name drugs and 125% of AWP for generics with an added \$4.00 dispensing fee per prescription has ensured that its reimbursement levels will remain at a reasonable rate typical of workers' compensation systems in other states.

The Division's adopted pharmacy fee guideline for prescription drugs also ensures access to prescription medications and services for injured employees for several reasons. First, as stated in the Milliman Report, its allowable reimbursement exceeds the reimbursement levels seen in other non-workers' compensation markets, such as the group health model, but this excess is reasonably necessary to ensure injured employees have sufficient access to prescription medications and services. The Division's adopted pharmacy fee guideline must consider any risks of non-payment and administrative costs found in workers' compensation, but not found in other markets. Specifically, pharmacists who choose to participate in the Texas workers' compensation system and dispense drugs to injured employees must have a different business model compared to those engaged in group health or retail markets. When processing workers' compensation prescriptions,

pharmacists must also verify compensability and workers' compensation insurance coverage; bill the insurance carrier; interact with pharmacy benefit managers (PBMs) or other authorized insurance carrier agents; and participate in medical necessity and/or medical fee dispute resolution processes when there are any issues related to reimbursement, non-payment or underpayment of the bill.

Pharmacists essentially assume the risk of having no payment, or underpayment, as well as the cost of the medical dispute resolution and the delay resulting from it since there is no immediate adjudication of disputes. This is unlike the group health model. It should be noted that some pharmacists do utilize processing agents for billing purposes who may be willing to accept some of this risk in exchange for a portion of the pharmacists' payment; however, it is important to note that not all pharmacies utilize processing agents and not all processing agents accept risk.

Furthermore, the Division must be mindful that the pharmacies to which the pharmacy fee guideline will apply are pharmacies that have elected not to, or have been unable to, contract with insurance carriers or their authorized agents for a specific fee schedule. Therefore, these are the pharmacies that will not benefit from any expedience or other administrative advantages that may result from participating in an informal or voluntary pharmacy network. The Division's pharmacy fee guideline, therefore, must take into account not only the additional costs of participating in the workers' compensation system but also the particular selection of pharmacies to which the reimbursements will apply in order to ensure sufficient access to prescription medications and services for injured employees. As WCRI concluded in its June 2006 study entitled *The Cost and Use of Pharmaceuticals in Workers' Compensation: A Guide for Policy Makers*, "fee schedules set at the levels of group health insurance or government programs, without companion public policies that reduce the special friction costs [of providing pharmaceutical services in workers' compensation systems], increase the risk of reducing access to care."

The Division's adopted pharmacy fee guideline also ensures that injured employees will have sufficient access to prescription medications and services because the adopted rule retains the same reimbursement formulas that have been in §134.503 since 2002 and ensures market stability. As previously stated, the Division's replacing of "usual and customary" with "amount billed," the Division's implementation of HB 528, and the Division's newly effective closed formulary will all have substantial impact on the provision of prescription medications and services in the Texas workers' compensation system. Retaining the same reimbursement formulas will ease this already significant transition and help ensure that health care providers are willing to remain in the system.

The Division's adopted pharmacy fee guideline for prescription drugs also minimizes costs to insurance carriers and injured employees and takes into consideration the increased security of payment provided by the Act for several reasons. First, the Division's adopted pharmacy fee guideline provides a wholly objective method of determining the appropriate reimbursement for any particular pharmacy bill, and, therefore, should diminish pharmacy fee disputes and dispute costs. Previously, the evidence required to prove, and varying interpretations of, "usual and customary" led to more frequent and more complicated disputes regarding reimbursement for prescription drugs and services. According to Division data, nearly 6,300, or approximately 92% of all pharmacy fee disputes filed with the Division since January 1, 2005, involved one or both parties raising the health care provider's "usual and customary charge" as an issue in the dispute. Thus, in addition to being consistent with the legislative intent discussed previously, removing the health care provider's usual and customary charge from the pharmacy fee guideline and replacing it with an objective standard is good policy.

The Division's adopted pharmacy fee guideline for prescription drugs and services also minimizes costs and takes into consideration the increased security of payment provided by the Act

because it avoids any immediate, non-required reimbursement rate changes that would lead to mass transaction costs as system participants adapt their business models and contracts to recent statutorily-required changes. A change in the current reimbursement formula, in addition to the statutorily-required changes discussed above, would require a re-tooling of the reimbursement systems currently in place in the Texas workers' compensation system resulting in additional costs for insurance carriers and delayed implementation of the adopted fee structure as required by HB 528. Further, a change in the AWP benchmark at this time might only be an interim replacement until a permanent benchmark is identified and determined as a suitable replacement for AWP. This approach could result in multiple and costly programming changes throughout the system; increase confusion concerning reimbursement; and create opportunities to increase medical fee disputes.

Furthermore, because the Division's adopted pharmacy fee guideline retains the same reimbursement formulas that have existed in §134.503 since 2002, they will permit the Division to gather information on the system impacts of other statutorily-required changes to pharmaceutical reimbursements, national trends regarding the appropriate benchmarks for pharmaceutical reimbursement rates and help the Division avoid multiple interim changes that could lead to increased stakeholder costs and confusion. Additionally, the Division will be able to examine the impact the new pharmacy closed formulary has on drug utilization and pharmacy claims costs in the Texas workers' compensation system. One of the primary policy goals in adopting a pharmacy closed formulary was to reduce unnecessary utilization of certain drugs, such as specific narcotics, in the Texas workers' compensation system. Initiating a change in the pharmacy reimbursement formula while implementing the other statutorily-required changes will confound any analysis of the impact of the pharmacy closed formulary on medical costs and utilization of care. Thus, the Division must have information on the impact its pharmacy closed formulary has on these trends, and on the

impacts of its other changes made in this adoption order, before it can make a fully informed and long-term decision regarding a new reimbursement formula.

Lastly, as previously stated, the Division's adopted pharmacy fee guideline for prescription drugs and services ensures that reimbursement for prescription medication in Texas remains typical of workers' compensation reimbursement for prescription drugs in other states.

Section 134.503(d) is the pharmacy fee guideline for nonprescription drugs or over-the-counter medications and complies with Labor Code §408.028(f). This adopted reimbursement continues the reimbursement for nonprescription drugs or over-the-counter medications that have existed in §134.503 since 2002. The reimbursement for nonprescription or over-the-counter medication shall be the retail price of the lowest package reasonably available that will fill the prescription. Continuing this reimbursement will assure stability in the Texas workers' compensation system, provide reimbursements that are fair and reasonable, and ensure security of payment to health care providers because the reimbursement for nonprescription drugs or over-the-counter medications is the same as the amounts charged by the health care provider to consumers purchasing these drugs and medications at retail prices. It also is an objective standard that is easily determined and therefore will ensure clarity to health care providers as to reimbursement. This reimbursement also reduces costs for insurance carriers because it caps the reimbursement at the same level as is paid by other consumers paying retail prices and limits reimbursement to lowest quantity reasonably available that will fill the prescription. Further, as stated, this reimbursement is an objective standard, easily determined, which will reduce disputes, and therefore the costs associated with disputes, over the proper reimbursement amounts for nonprescription drugs or over-the-counter medications. Finally, this reimbursement assures adequate access to medications and services for injured employees because it assures reimbursement for health care providers at levels

that are the same as the amounts provided by other consumers outside the workers' compensation system.

Section 134.503(e) is the pharmacy fee guideline for cases where an amount cannot be determined under §134.503(c)(1) or (d), as applicable, and no contracted rate exists. The Division anticipates that these situations will be extremely rare. Therefore, the reimbursement amount in these cases will be an amount that is consistent with the four factors in Labor Code §408.028(f), including providing for reimbursement rates that are fair and reasonable. In order to implement the reimbursement methodology in this subsection, this subsection requires insurance carriers to: (1) develop a reimbursement methodology(ies) for determining reimbursement under this subsection; (2) maintain in reproducible format documentation of the insurance carrier's methodology(ies) for establishing an amount; (3) apply the reimbursement methodology(ies) consistently among health care providers in determining reimbursements under this subsection; and (4) upon request by the Division, provide to the Division copies of such documentation. Imposing these requirements will reduce any uncertainty in reimbursements under this subsection. These requirements will also promote consistency in reimbursement amounts determined under this subsection and create consistency among Division fee guidelines because they are similar to the requirements imposed on insurance carriers by 28 TAC §134.1(g) of this title (relating to Medical Reimbursement) which govern fair and reasonable reimbursements under other Division fee guidelines.

Amended §134.503(f) provides that a contracted fee arrangement will govern the reimbursement of prescription medication or services, as defined by Labor Code §401.011(19)(E), if the contract complies with the provisions of Labor Code §408.0281. This is consistent with the provisions of that statute that allow for the contracting for fees that are inconsistent with the fee guidelines in this section. As stated in the discussion above regarding Labor Code §408.0281, the

contract must meet several requirements before reimbursements may be made at the contracted rate. This rule therefore provides that reimbursements for prescription medication or services may be at contracted rates that are inconsistent with the pharmacy fee guideline if the contract complies with the provisions of Labor Code §408.0281 and applicable Division rules.

3. HOW THE SECTIONS WILL FUNCTION.

The adopted rule amendments set forth a framework within which system participants in the Texas workers' compensation system are provided a guideline for pharmacy fees that clarifies the Texas workers' compensation system's reimbursement for prescription drugs and nonprescription drugs or over-the-counter medications.

§134.503

Adopted §134.503(a) provides that the pharmacy fee guideline applies to prescription drugs and nonprescription drugs or over-the-counter medications as defined in §134.500 of this title (relating to Definitions) for outpatient use in the Texas workers' compensations system. The pharmacy fee guideline applies to both claims subject to a certified network and claims not subject to a certified network, including claims that are handled by a political subdivision or pool under Labor Code §504.053(b)(2). It does not apply to parenteral drugs.

Under adopted subsection (b), system participants shall apply the provisions of Chapter 133 and 134 of this title (relating to General Medical Provisions and Benefits--Guidelines for Medical Services, Charges, and Payments, respectively) for coding, billing, and reimbursement of prescription and nonprescription drugs or over-the-counter medications.

Adopted subsection (c) is the pharmacy fee guideline for prescription drugs. Subsection (c)(1)(A) and (B) establish the reimbursement formulas for prescription drugs which are consistent

with the previous version of this rule. Additional language has been added to subsection (c)(1)(A) and (B) to clarify that the \$4.00 dispensing fee is per prescription. Subsection (c)(1)(C) clarifies that when compounding, a single compounding fee of \$15 per prescription shall be added to the calculated total for either generic or brand name drugs. Subsection (c)(2) states that notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed will be the amount that is billed to the insurance carrier by the health care provider. 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 amount billed will be the amount that is billed to the insurance carrier by the pharmacy processing agent. Determining the amount billed under subsection (c)(2) is an objective inquiry based solely on the amount shown on that particular bill to the insurance carrier by the health care provider or pharmacy processing agent. In other words, when an insurance carrier receives a bill for pharmaceutical services from a health care provider or pharmacy processing agent, the "amount billed" that will be compared to the formula amount for generic drugs or brand name drugs will be the specific amount shown on that particular bill. Insurance carriers may not substitute any other billed amount. Adopted subsection (c)(2) replaces "usual and customary charge" with amount billed.

Adopted subsection (d) is the Division pharmacy fee guideline for nonprescription drugs or over-the-counter medications. It provides that reimbursement for nonprescription drugs or over-the-counter medications shall be the retail price of the lowest package quantity reasonably available that will fill the prescription.

Adopted subsection (e) is the Division pharmacy fee guideline when an amount cannot be determined under subsection (c)(1) or (d), as applicable, and no contract amount exists. It sets forth that, except as provided by subsection (f) of this section, reimbursement shall be an amount that is

consistent with the criteria listed in Labor Code §408.028(f), including providing for reimbursement rates that are fair and reasonable. The insurance carrier shall develop a reimbursement methodology(ies) for determining reimbursement under this subsection, maintain in reproducible format documentation of the insurance carrier's methodology(ies) for establishing an amount, apply the reimbursement methodology(ies) consistently among health care providers in determining reimbursements under this subsection, and upon request by the Division, provide copies of such documentation to the Division. Reimbursement under this subsection is determined on a case-by-case basis and depends on the facts and circumstances surrounding the particular pharmaceutical service.

Adopted subsection (f) states that notwithstanding the provisions of this section, prescription medication or services, as defined by Labor Code §401.011(19)(E), may be reimbursed at a contract rate that is inconsistent with the fee guidelines as long as the contract complies with the provisions of Labor Code §408.0281 and applicable Division rules. This subsection conforms to statutory provisions of HB 528 that allow insurance carriers and health care providers to contract for fees that are inconsistent with the Division's pharmacy fee guideline in an amount greater or less than the fee guideline. Contractual reimbursements under this section are not part of the Division's pharmacy fee guideline.

Subsection (g) governs how health care providers are to be reimbursed under this section when the prescribing doctor has written a prescription for a generic drug or a prescription that does not require the use of a brand name. These provisions were located in subsection (b) of the previous rule. The adopted amendments to this subsection make clarifications in nomenclature, which are not substantive amendments. The adopted amendments also conform references in this subsection to other parts of this section.

The amendments to subsection (h) make changes in nomenclature and conforming changes in references to other parts of this rule. These adopted amendments are not substantive.

The adopted amendments in subsection (i) also make changes in nomenclature. The adopted amendments also permit the Division to require the insurance carrier to disclose the source of the nationally recognized pricing reference used to calculate the reimbursement. This adopted amendment conforms to current nomenclature.

Adopted subsection (j) states that where any provision of this section is determined by a court of competent jurisdiction to be inconsistent with any statutes of this state, or to be unconstitutional, the remaining provisions of this section shall remain in effect.

§134.504

Section 134.504 governs pharmaceutical expenses incurred by the injured employee. The adopted amendments to §134.504 are conforming amendments to correct references in this rule to §134.503 in light of the amendments to §134.503.

4. SUMMARY OF COMMENTS AND AGENCY'S RESPONSES.

General: Commenters compliment the Division's proposed rules, and some state the amended rules are necessary to implement portions of HB 528. Some commenters note their appreciation of the opportunity to discuss these concepts informally prior to proposal, and in the Division's action since the passage of HB 528.

Agency Response: The Division appreciates the supportive comments.

General: A commenter suggests that minimizing pharmacy costs matters to Texas employers and their workers, and the relevant statute requires the Division to minimize pharmacy costs. The commenter cites numerous quoted premium and subscriber related figures from the Texas

Department of Insurance (Department) *Setting the Standard: An Analysis of the Impact of the 2005 Legislative Reforms on the Texas Workers' Compensation System, 2010 Results*, and the Department and Division's *Biennial Report of the Texas Department of Insurance to the 82nd Legislature: Division of Workers' Compensation* (Biennial Report).

Agency Response: The Division agrees that minimizing costs is one of the statutory criteria required for a pharmacy fee guideline in Labor Code §408.028(f). Labor Code §408.028(f) also requires the Commissioner to adopt a pharmacy fee guideline that will provide reimbursement rates that are fair and reasonable; assure adequate access to medications and services for injured employees; and take into consideration the increased security of payment afforded by the Act. As set forth in this adoption order, the adopted pharmacy fee guideline complies with the statutory requirements in Labor Code §408.028(f).

General: A commenter states that about 75% of its pharmacy reimbursements are under contracts with a pharmacy benefit manager (PBM), which in turn contracts with the pharmacy. The commenter further states that it reimburses other pharmacies that do not contract with a PBM using an estimate of their usual and customary charges based in part on data from its PBM payments. The commenter states that its reimbursement levels are substantially less than AWP and that these reimbursement levels have caused no access problems. Additionally, the commenter understands that the Division intends that this rule would not prevent it from using its PBM arrangements.

Agency Response: The Division clarifies that Labor Code §408.0281 permits insurance carriers and health care providers to contract for rates that are inconsistent with the pharmacy fee guideline if the contract meets the requirements of that section and applicable Division rules. The Division has added the language "and applicable division rules" to adopted subsection (f) for the purpose of clarifying that the contractual fee arrangement between the insurance carrier and health care

provider must also comply with any applicable Division rules. In light of HB 528 and other reasons set forth in this adoption, the Division also clarifies that insurance carrier reimbursement pursuant to the pharmacy fee guideline may no longer be based upon the health care provider's "usual and customary charges for the same or similar service." The Division disagrees with the commenter to the extent that the commenter suggests that it may reimburse a health care provider under the pharmacy fee guideline by using its own estimate of the health care provider's usual and customary charge; estimate of the health care provider's billed amount; or an estimate of the health care provider's contracted amount.

§134.503(a)(2): Because the term "parenteral drugs" is not defined in §134.500, commenters recommend added text: "This section does not apply to parenteral drugs administered intravenously by a health care provider." The commenters state it appears that the term is commonly understood to refer to any drug that is not consumed by the patient orally. Consequently, the commenters state this rule exclusion would apply not only to drugs administered intravenously, but would also apply to transdermal drugs, suppositories, and nasal inhalants. The commenters state that if the parenteral drug has a published AWP and can be safely administered by the patient, then the formulas in subsection (c) should apply for reimbursement. Other commenters believe that only medications administered intravenously are to be excluded from the fee schedule and recommend clarification. Additionally, a commenter recommends that if the Division elects to not amend the proposed language to clarify this provision of the rule, the Division's response should specifically address the points raised in this comment recommendation to make it as clear as possible that this provision shall not be used by pharmacies to "skirt" the guidelines to pursue reimbursement at a level greater than that set forth in the fee guideline. The commenter suggests this is especially important in regard to the reimbursement of compounded drugs.

Agency Response: The Division declines to make the recommended change. The Division's Medical Advisor has reviewed the comments pertaining to parenteral drugs and noted that the term "parenteral" encompasses only needle injections of substances through the skin or mucous membranes. Prescription drugs and nonprescription drugs or over-the-counter medications administered through patches, absorbable lotions or creams, as well as transdermal drugs, suppositories, and nasal inhalants are not parenteral drugs and, therefore, are subject to the requirements in the adopted rule. Reimbursement for parenteral drugs is covered by other Division fee guidelines in 28 TAC Chapter 134.

In response to the comment suggesting that certain self-administered parenteral drugs be included in the Division's pharmacy fee guideline, the Division disagrees and declines to include the suggested changes. There may be rare instances where a patient self-injects a parenteral drug such as a diabetic patient self-injecting with insulin subcutaneously, intravenous port use for anti-neoplastic drugs by a cancer patient, and other rare circumstances when a doctor takes responsibility for the patient's training for self-administered medications intramuscularly, percutaneously, or intravenously through an established port. An attempt to prospectively bifurcate parenteral drugs based on the person administering the drug would add unnecessary complication and potential confusion to the system. The adopted reimbursement methodologies are consistent with the methodologies adopted in 2002 which have been applied by system participants with few disputes, if any, concerning appropriate reimbursement.

Further, the reference to parenteral drugs included in this paragraph is a restatement of the reference in previous rule §134.503, which was originally adopted in 2002. The use of parenteral is consistent with the Food and Drug Administration's (FDA) terminology and has not proved confusing

or problematic for system participants since its original adoption. Any modification or elaboration of the term could lead to system participants' confusion over the common understanding of parenteral.

§134.503(b): A commenter states that subsection (b) directs all system participants to follow the rules in Chapters 133 and 134. The commenter states §133.240, a Chapter 133 rule, provides that when an insurance carrier remits payment to a pharmacy processing agent, the pharmacy's reimbursement shall be made in accordance with the terms of its contract with the pharmacy processing agent. The commenter states that an insurance carrier has to know the terms of the contract in order to ensure that the carrier has not made a payment that is inconsistent with the fee guideline. The Division should explain, how in the absence of the contracts, the insurance carrier can enforce a meaningful application of the statutes and rules. The commenter assumes that this was not intended, but the proposed fee guideline, as worded, could be argued to conflict with §133.240(m). The Division should clarify that the insurance carrier has the right to not pay an amount that it believes is in excess of the actual health care provider's billed or contracted amount.

Agency Response: The Division disagrees that §133.240(m) conflicts with the Division's pharmacy fee guideline. Section 133.240(m) applies when insurance carriers are reimbursing a pharmacy processing agent. An insurance carrier's reimbursement to a pharmacy processing agent must comply with the Division's pharmacy fee guideline or a contract between the insurance carrier and the pharmacy under Labor Code §408.0281. Once the pharmacy processing agent receives reimbursement, the processing agent shall reimburse the pharmacy in accordance with the terms of its contract with the pharmacy. Thus, an insurance carrier does not need to know the terms of the contract between the pharmacy processing agent and the pharmacy to comply with this adopted rule. "Amount billed" under subsection (c)(2) is determined by the amount that is billed by a pharmacy or pharmacy processing agent to an insurance carrier in accordance with subsection

(c)(2)(A) and (B), and, in response to this comment, the Division has added to adopted subsection (c)(2) and (c)(2)(B) the language “to the insurance carrier” and “the insurance carrier” to clarify this point. Additionally, the Division clarifies that insurance carriers may not estimate or modify a health care provider’s billed amount or account for a health care provider’s appropriate level of reimbursement under its contract with a pharmacy processing agent when an insurance carrier reimburses a pharmacy or pharmacy processing agent under the Division’s pharmacy fee guideline.

§134.503(b): A commenter opines that §133.307(c)(2)(H) requires a pharmacy processing agent participating in medical fee dispute resolution (MFDR) to submit to the MFDR section a signed and dated copy of an agreement between the processing agent and the pharmacy that clearly demonstrates the dates of service covered by the contract and a clear assignment of the pharmacy’s right to participate in the MFDR process. If the contract is necessary for MFDR to adjudicate a dispute over the guideline amount, then the pharmacy processing agent needs to submit its contract with every bill to the insurance carrier.

Agency Response: The Division declines to make the commenter’s recommended change, because the commenter’s concerns are outside the scope of these rules. Neither §134.503 nor §134.504 detail the appropriate manner for submitting medical bills for pharmaceutical services; instead, these sections simply clarify that the Division’s adopted billing procedures in other sections of Chapters 133 and 134 of this title govern this issue. These adopted rules, however, only address reimbursement for pharmaceutical services and, as explained above, the terms of a contract between a pharmacy and a pharmacy processing agent are not applicable to the amount an insurance carrier reimburses for pharmaceutical services adopted under this rule.

§134.503(c): A commenter recommends that to comply with its statutory duty to minimize costs, the Division should provide separate and lower fees for prescriptions filled by mail order pharmacies. If the Division insists on continuing to use AWP at all, the commenter recommends that the AWP formula for mail order pharmacies should be AWP at 85% for generic plus a \$4 dispensing fee, and AWP at 95% for brand name drugs plus a \$4 dispensing fee. The commenter states that mail order pharmacies are becoming more prevalent within the workers' compensation industry, and they currently compete with Main Street pharmacies, which have higher overhead costs. The one-size fits-all approach in the proposed pharmacy fee guideline fails to achieve the statutory objective of minimizing costs to employees and insurance carriers. To avoid creating an incentive for abuse, the Division should at least create a different reimbursement structure for mail order pharmacies that target workers' compensation exclusively.

Agency Response: The Division declines to add separate reimbursement methodologies in the adopted rule at this time to address mail order pharmacies. The Division does not have available data that would allow the Division to determine a rate, either higher or lower than the rates included in subsection (c), specific to mail order pharmacies. Without access to information regarding the use of mail order pharmacies and specific information concerning the cost and reimbursement structure of mail order pharmacies versus retail pharmacies, setting a unique reimbursement methodology for mail order pharmacies could lead to unintended and unforeseen consequences regarding injured employees' timely access to prescription drugs. However, if in the future the Division gains access to such information, then the Division will determine whether additional clarification to the existing pharmacy fee guideline reimbursement methodology is needed.

§134.503(c)(1): Commenters recommend amending (c)(1) to read as follows: "the fee established by the following formulas as applied only to ingredients with a National Drug Code (NDC) as

dispensed and based on the average wholesale price (AWP) as reported by the original labeler of drug product to a nationally recognized pharmaceutical price guide or other publication”

Commenters recommend this text to address two issues, one related to repackaging and the other related to compounding.

With regard to repackaging, commenters recommend this language because there may be more than one AWP applicable to a dispensed prescription drug either from the original manufacturer of the drug product or from a repackaging company, which breaks down that quantity into smaller units to sell to health care providers that dispense drugs. Under federal law, the repackaging company may assign and publish a new AWP for the drug. According to the commenters, this practice has been used in other jurisdictions to circumvent adopted fee schedules and grossly inflate drug reimbursement rates. The commenters state that the Division should look to various jurisdictions that have already either addressed or are in the process of addressing both compounding and repackaging issues, namely: California, Arizona, Oklahoma, Mississippi, Alabama, Georgia, and Maryland. If not, commenters suggest the Division should be open to the idea that once more data becomes available as to whether or not this is an existing problem in Texas, that they be amenable to either a rule petition or a proactive approach to address the issues at that time.

With regard to compounding, the commenters recommend this language because compounded drugs may include ingredients (saline, petroleum jelly, talc, baking soda, etc) which do not have an assigned NDC and consequently do not have a published AWP. Compounded drugs may include ingredients which do not have an assigned NDC and consequently do not fit the definition of “nonprescription drugs or over-the-counter medications” found in §134.500(8) and would not be reimbursed under §134.503(d). Commenters state that an unscrupulous pharmacy or processing agent may attempt to circumvent the pharmacy fee schedule by arguing that an amount

cannot be determined in accordance with subsections (c)(1) or (d). If that argument is correct, then reimbursement would default to fair and reasonable standards consistent with Labor Code §408.028(f). This could lead to costly fee disputes over compounded drugs that contain ingredients that are not labeled and packaged in compliance with state or federal law and for which there is no discernible therapeutic value to the injured employee.

Agency Response: The Division declines to adopt the commenters' recommended text. For the reasons stated in this adoption order, the Division has allowed for the use of AWP assigned to the NDC number of the drug dispensed. The commenters state that the repackaging issue has been used in other jurisdictions to circumvent adopted fee schedules and to grossly inflate drug reimbursement rates. However, the Division does not possess any data or other information that shows that this practice of circumventing adopted fee schedules and grossly inflating drug reimbursement rates is occurring in Texas. Studies published by entities such as the National Council on Compensation Insurance and the California Workers' Compensation Institute have attempted to quantify the cost impact of drug repackaging, but these studies only focus on repackaging costs as they relate to physician dispensing of prescription drugs. Texas statutes do not currently permit physician dispensing of prescription drugs, except in limited rural areas of the state. Should Texas statutes change to allow greater physician dispensing of prescription drugs, the Division will revisit this issue to determine if additional rulemaking is needed. Further, the Division notes that the adopted text in subsection (c)(1) is similar to text that has existed in §134.503 since 2002 and this adopted paragraph will not require the industry to implement any changes. In light of the absence of data showing such harm, there appears to be no cost benefit in adopting the recommended text.

With regard to the commenters' compounding issue, the Division determines that the suggested text is not necessary. Under the adopted rule, each prescription drug included in a compound drug will be reimbursed in accordance with the applicable formula in subsection (c)(1)(A) or (B) which will include the \$4.00 dispensing fee per prescription. Subsection (c)(1)(C) also includes a single \$15.00 compounding fee per prescription.

Pharmacists are required to list each drug included in the compound and calculate the charge for each drug separately in accordance with §134.502(d)(2). The inclusion of a substance without an NDC number will not cause the application of adopted subsection (e) in determining reimbursement for the individual prescription components of the compound drug that do have an NDC number. If an amount for any individual component of a compound drug cannot be determined under subsection (c)(1) or (d), reimbursement for that individual component will be governed by subsection (e) of this section.

§134.503(c)(1): Commenters raised concerns that with the deletion of an AWP pricing book reference (e.g., Red Book and First Data Bank), stating that the proposed language of a nationally recognized published pricing data will create conflict and potential disputes over the pricing difference between the sources, including the pricing data in effect on the day the prescription drug is dispensed. A commenter inquires if the pharmacies are billing off of one source, but the payers are paying off a different source, who wins, and whose source is to take precedence. Such discrepancies can cause difficulties in creating a business model with some degree of certainty. Commenters specifically recommend that the rule identify one publication, and that publication be MediSpan since MediSpan is updated more frequently and therefore contains the most current

pricing data. A commenter recommends the rule be amended to allow a single nationally recognized pharmaceutical guide that will provide for cost control and a fair rate of reimbursement.

Agency Response: The Division declines to make the recommended change and clarifies that the deletion of the examples from the adopted rule does not change the previous requirement to use a nationally recognized source of AWP to establish the reimbursement amount. The examples are removed to accommodate the potential for change in publishers of such data, which could cause confusion among system participants, and avoid the impression that the Division endorses any specific AWP price guide. The use of multiple nationally recognized pricing guides has been in place in the Texas workers' compensation system since 2002 with few disputes.

§134.503(c)(1): Commenters support the proposed pharmacy fee guideline that maintains the current reimbursement rates based on AWP. Commenters indicate that while the health care industry continues to look for a better pricing benchmark, AWP remains the most widely accepted standard at this time. A commenter describes the high degree of risk involved in providing prescription care to injured employees and believes a state fee schedule should act as a safety net to the injured employees allowing pharmacies the ability to reduce the uncertainty in obtaining prescription care. The commenter further cites the March 2010 study conducted by WCRI that evaluated pharmaceutical spending in 16 states, including Texas, asserting that the drivers of cost within the workers' compensation system center on utilization and prescribing patterns. The commenter states the study also indicates that lowering fee schedules do little to influence prescriber behavior, and instead block access to care.

Agency Response: The Division appreciates the supportive comments. The Division agrees that AWP remains the most widely accepted standard at this time and notes numerous resources were researched and considered in the development of this adopted rule, including those noted by the

commenters. Additionally, the Division notes that the requirements of the Division's adopted fee guideline are set forth in Labor Code §408.028(f).

§134.503(c)(1): A commenter recommends AWP be replaced with a standard that minimizes costs.

In proposing to continue the use of the existing rule's AWP formula, the proposed pharmacy fee guideline violates and exceeds the statutory authority of the Division set forth in the Act because continued use of AWP does nothing to minimize costs as required by Labor Code §408.028(f)(3), and the notice of the proposed rule states no factual basis for believing that continued use of AWP does minimize cost. The commenter further opines that the proposed rule contains no discussion of the facts of AWP whatsoever, while recent national development facts on AWP that are readily available, and not disputed, show reliance on AWP reimbursement as fundamentally flawed. Additionally, the commenter contends that the notice of the proposed rulemaking states no factual basis for believing that continued use of AWP is: [1] necessary to ensure adequate access to medications and services to injured workers as required by Labor Code §408.028(f)(2); [2] necessary to ensure fair and reasonable reimbursement rates as required by Labor Code §408.028(f)(1); and [3] appropriate when the Division takes into consideration the increased security of payment afforded by this subtitle, as required by Labor Code §408.028(f)(4). The commenter urges the Division to either provide explanation of legal and factual reasons why this perceived threat to the company's cost savings does not exist, or commit to changes to the proposed rule that will eliminate the perceived threat.

Agency Response: The Division declines to change the AWP benchmark at this time. The Division notes that any benchmark by itself does not determine a final reimbursement rate. The use of AWP is but one component of the reimbursement formula adopted by the Division to establish

reimbursement rates for pharmaceutical services. There are alternative benchmarks; however, they serve as a point by which to multiply the rate of reimbursement.

The Division held meetings with system participants on February 2, 2010 and again on November 16, 2010, and one agenda topic for discussion was the use of AWP versus other benchmarks. A presentation with a summary of seven common pricing benchmarks was provided at the February 2, 2010 meeting, and further details of each benchmark were presented in breakout sessions at the two Division Education Conferences in 2010. Throughout this rulemaking process, there have been discussions with system participants about the use and necessity of an alternative benchmark, and the majority of system participants agreed with the conclusions of the Division that there is no suitable replacement for AWP in the industry at this time.

Furthermore, AWP is the most commonly used benchmark in the health care industry as well as workers' compensation systems, based on an excerpt from the Milliman Report, "The most common formula for defining pharmacy reimbursement levels in all markets (e.g., commercial, Medicare, Medicaid, workers' compensation), is a percentage of AWP (most commonly a discount) plus a dispensing fee for a prescription." Additionally, WCRI's *Workers' Compensation Medical Cost Containment: A National Inventory, 2011* shows that out of 34 workers' compensation state jurisdictions that provide pharmacy reimbursement direction, 29 use AWP as their benchmark.

§134.503(c)(1)(A) - (C): Commenters suggest reliance on Centers for Medicare and Medicaid Services (CMS) methodologies in accordance with the provisions of Labor Code §413.011 may not be appropriate at this time with regard to the pharmacy fee schedule; but also suggests that once CMS adopts a singular and consistent methodology for pharmaceutical reimbursement, the Division may have to abandon the current AWP methodology and adopt the CMS methodology with minimal modifications in order for the system to have a statutorily valid pharmacy fee guideline.

Agency Response: This adoption continues the use of AWP as the benchmark for pharmaceutical reimbursement in the adopted rule. As pharmacy reimbursement benchmarks and methodologies continue to evolve, the Division will monitor and consider these developments for possible future rulemaking.

§134.503(c)(1) - (2): A commenter recommends keeping as a reimbursement limit the pharmacy's usual and customary charge, or replacing it with retail cash price, with the following suggested language: "the health care provider's retail cash price that it charges to walk-in customers." The commenter suggests pharmacies might argue that the removal from the rule of the pharmacy's "usual and customary charge for the same or similar service" as one of the lesser reimbursement levels to which reimbursement is limited, and its replacement with "amount billed by the health care provider," allows pharmacies to bill more to workers' compensation insurers for prescriptions to covered workers than they can bill other patients, and that the insurer would be required to pay the higher amount up to (under the current proposal) the AWP-plus formula amount. Such a rule would violate the minimize costs statutory requirement and unconstitutionally delegate pharmacy reimbursement to the pharmacy itself. The commenter's company would directly and immediately be threatened to increase, rather than minimize, the portion of its pharmacy reimbursements that go to pharmacies that do not contract with its PBM.

Agency Response: The Division declines to make the recommended changes. The commenter's alternate language would result in some form of a "usual and customary charge" consideration by the insurance carrier, which would circumvent the statutory amendments in HB 528 that eliminate the Division's requirement to consider "usual and customary charge" when developing a pharmacy fee guideline. Also, as set forth in this adoption order, the adopted pharmacy fee guideline in this rule complies with the cost saving provisions in Labor Code §408.028(f).

Additionally, the Commissioner received a letter of legislative intent of HB 528 and specifically of House Floor Amendment No. 1, responding to submitted public comment. The letter notes that the commenter, by stating that the pharmacy fee guideline rule should include reimbursement at usual and customary rates, ignores the changes in statute made by HB 528 on this specific topic. HB 528 repealed the HB 7 provision regarding §408.028(g) and further amended subsection (g) by setting forth that Labor Code §413.011(d), and the rules adopted to implement that subsection, do not apply to the pharmacy fee schedule. The statement of legislative intent stated that the use of “usual and customary” in the pharmacy fee guideline was extremely costly to the overall system because of the very large number of pharmacy fee disputes filed with the Division that involved application of that term.

Furthermore, the amount billed under adopted subsection (c)(2) is a more objective inquiry than “usual and customary” and is determined based solely by the billed amount the health care provider or pharmacy processing agent submits on the medical bill. This objective approach allows for more consistent application of the pharmacy fee guideline, thereby eliminating fee disputes over what constitutes a health care provider’s “usual and customary charge.”

§134.503(c)(1)(A) - (B): A commenter recommends that if the Division is not willing or not able to change the basis of an acquisition-cost basis formula from AWP at this time, the Division must at least consider changing the formula from AWP plus to AWP minus. The commenter recommends the Division adopt an AWP formula at 96% of AWP for brand name drugs, and 88% of generics, in each case plus a \$4 dispensing fee. This commenter contends that the notice of the proposed rulemaking states no factual basis for believing that continued use of AWP plus 25% for generics and plus 9% for brand name formulas: [1] minimizes costs as required by Labor Code §408.028(f)(2); [2] is necessary to ensure adequate access to medications and services to injured

workers as required by Labor Code §408.028(f)(2); [3] is necessary to ensure fair and reasonable reimbursement rates as required by Labor Code §408.028(f)(1); and [4] is appropriate when the Division takes into consideration the increased security of payment afforded by this subtitle, as required by Labor Code §408.028(f)(4). The commenter provides excerpts from the Division's report from Milliman entitled, *Pharmaceutical Reimbursement Comparison Report*, that the commenter believes support the commenter's recommendation of an AWP minus reimbursement approach, and that such a formula produces reimbursements that pharmacies accept as fair and reasonable.

Agency Response: The Division declines to adopt the AWP formulas recommended by the commenter. For the reasons set out in this adoption order, the adopted pharmacy fee guideline meets the requirements under Labor Code §408.028(f) at this time. The Division notes that the reimbursement rates included in the adopted §134.503 (relating to Pharmacy Fee Guideline) are the same rates as provided in previous §134.503 (relating to Reimbursement Methodology). Consistent application of the methodology should not result in any cost increase to insurance carriers. The rates included in the Milliman Report reflect average reimbursement for all carriers and include reimbursements greater than and less than 96% of AWP for name brand drugs, and greater than and less than 88% of AWP for generic drugs. Further, the range of reimbursements extends from 41% to 132% of AWP for brand name drugs, and 16% to 142% of AWP for generic drugs. Although the Milliman Report indicates Texas workers' compensation reimbursement is significantly above that seen in other health markets that included Medicare, Medicaid, and commercial group health plans, Milliman notes that based on their research citing WCRI and NCCI, the Texas fee schedule was typical of workers' compensation fee schedules in other states.

Furthermore, in reviewing states' workers' compensation pharmacy fee schedules, the WCRI report, *Workers' Compensation Medical Cost Containment: A National Inventory*, January 2011,

reflects a range of 84% to 140% of AWP for brand name drugs and a range of 75% to 140% of AWP for generic drugs. Dispensing fees across state systems ranged from \$2.00 to \$10.67.

Regarding the assertion that an AWP minus reimbursement rate would result in an amount that is fair and reasonable, the Division believes that the previous and adopted reimbursement rates produce fair and reasonable reimbursement. Individual pharmacies may agree to rates that differ from the adopted reimbursement rates, which would also be considered fair and reasonable. The lowest common denominator does not necessarily indicate a global fair and reasonable amount that would meet the requirements of the Texas workers' compensation system or the requirements of the Labor Code.

§134.503(c)(1)(C): Commenters state that it appears the Division intends for compounded drugs to be reimbursed by the insurance carrier by applying the formulas in (1)(A) or (B) with a single compounding fee of \$15 per prescription replacing the \$4 dispensing fee found in those paragraphs of subsection (c)(1), and if such is the intention, then clarification is needed in the rule.

Agency Response: The Division disagrees that the \$15 compounding fee replaces the \$4.00 dispensing fee. The Division clarifies that the single compounding fee of \$15 per prescription is in addition to the calculations of subsection (c)(1)(A) and (B) that includes a single \$4.00 dispensing fee per prescription. There is not a separate dispensing fee for each component of a compounded drug. In order to make this clarification understood, the Division has added the terms, "per prescription" in both paragraph (1)(A) and (B) of the adopted rule. This added text makes clear that there will be one \$4.00 dispensing fee per prescription for both generic and brand name drugs. This adoption order maintains the previous methodology and reimbursement practice.

§134.503(c)(1)(C): A commenter states that inappropriate use of compound drugs has been a major cost driver of workers' compensation medical costs in a number of states and there is no

clinical evidence for the efficacy of non-FDA-approved compound drugs. Additionally, the majority of compound drugs that are administered topically have no proven clinical impact. The commenter suggests the proposed rules should require preauthorization for any use of a compound drug and justification set forth based on the patient's ability to tolerate a drug's inert substances.

The commenter recommends the following clarifying language to place restrictions on the use of compounding, and to dictate how compound drugs, when appropriate to dispense, should be reimbursed: "When compounding is medically necessary to treat the injured worker and has been preauthorized, the National Drug Code number and the actual amount used for each ingredient in the compound shall be provided and the charge for each drug is to be calculated separately using paragraph (1)(A) or (B) of the subsection, with a single dispensing fee of \$15 per prescription. If information pertaining to the original labeler of the underlying drug product used for the compound is not provided, the insurance carrier shall select the most reasonable and closely related AWP for reimbursement."

Agency Response: The Division declines to make the recommended changes. This commenter's concerns regarding preauthorization, billing, and bill processing requirements are addressed in other rules of Chapters 133 and 134 of the Division rules, and those rules are not within the scope of this adoption order. Subjective determinations of the "most reasonable and closely related AWP for reimbursement" where a specific NDC number was billed for the prescription drug, would cause unnecessary disputes.

The Division notes, however, that if an insurance carrier cannot determine reimbursement under §134.503(c)(1), (d), or (f), then the reimbursement rates shall be fair and reasonable in accordance with §134.503(e).

§134.503(c)(2): A commenter recommends the rule should delete “or pharmacy processing agents” because this phrase could be interpreted to allow pharmacy processing agents, which provide no health care at all, to set their own billed amounts for drugs and services provided by actual pharmacies, marked-up, and make insurers pay those marked-up charges all the way to AWP plus. The mark-up in the billed amounts by a pharmacy processing agent is not for health care. This unintended consequence would create an unwarranted burden on the system when no access problem justifies a large increase. Further, nothing in Labor Code §413.0111 or §408.028, or any other amendment to the Labor Code requires, or even authorizes, the Division to allow a processing agent who purchases receivables to mark-up the pharmacy’s own retail cash price and make the insurer pay the marked-up amount billed by the processing agent. With HB 528, Labor Code §408.0281 provides in part, “notwithstanding any other provision of the Act, an insurance carrier may pay a health care provider fees for pharmaceutical services that are inconsistent with the fee guidelines...” With the cited definition of processing agent from §133.2(7), the commenter suggests that if proposed (c)(2) did allow a pharmacy processing agent to set its own amount charged, different from and marked-up from, the pharmacy’s retail cash price, it not only would violate the statutory requirement to minimize costs, but would conflict with other rules governing the limited role of pharmacy processing agents. Also, the Division would have to demonstrate how allowing processing agents to mark-up would minimize pharmacy costs to insurers.

Agency Response: The Division declines to delete “or pharmacy processing agents” from the adopted rule because Labor Code §413.0111 specifically directs the Commissioner to adopt rules that authorize pharmacies to use agents or assignees to process claims and act on behalf of the pharmacies under terms and conditions agreed on by the pharmacies. The Legislature recognized the role of pharmacy processing agents as system participants in the Texas workers’ compensation

system as necessary when the Legislature enacted HB 7 during the 79th Legislature, Regular Session, and effective September 1, 2005. No provisions of Labor Code §413.0111 concerning the role of pharmacy processing agents in the reimbursement of prescription medication and services has been changed or repealed by HB 528.

The Division did not intend to allow for a situation where a pharmacy processing agent could mark-up a pharmacy bill. The Division has therefore changed the text in adopted subsection (c)(2) to prevent mark-ups of pharmacy bills. Adopted subsection (c)(2) now provides, "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."

Various scenarios may arise in the application of adopted subsection (c)(2). First, if a health care provider bills an insurance carrier for a pharmaceutical service the amount billed under subsection (c)(2) will be the amount included on the DWC-66 form or its electronic equivalent. Second, if a pharmacy processing agent bills an insurance carrier for a pharmaceutical service on behalf of the health care provider and the health care provider has not submitted a bill for that service, the amount billed under subsection (c)(2) is the amount included on the DWC-66 form or its electronic equivalent as submitted by the pharmacy processing agent. Third, if a health care provider submits a bill for a pharmaceutical service to an insurance carrier and subsequently a pharmacy processing agent submits a bill for the same pharmaceutical service, the amount billed under subsection (c)(2) is the amount listed on the health care provider's DWC-66 form or its electronic equivalent. The Division notes that regardless of these scenarios a contractual fee arrangement that is in place between the health care provider and insurance carrier and that

complies with applicable provisions of the Act and applicable Division rules will govern reimbursement for the pharmaceutical service.

The Division clarifies that determining the amount billed pursuant to §134.503(c)(2) is an objective inquiry, and is determined solely by the billed amount the health care provider, or pharmacy processing agent, submits on the particular DWC-66 form or its electronic equivalent. For example, when the insurance carrier receives a bill for pharmaceutical services from a pharmacy or a pharmacy processing agent, the amount billed to be compared to the formula amount in §134.503(c)(1) will be the amount billed as reflected on the bill. Accordingly, insurance carriers may not substitute any other billed amount.

§134.503(c)(2): The commenter recommends deleting the language in proposed §134.503(c)(2) that makes §133.20(e) inapplicable to the reimbursement calculation. The proposed §134.503(b) requires all system participants to use the Chapter 133 and 134 billing and coding rules. However, proposed §134.503(c)(2) makes §133.20(e) (relating to the prohibition against billed charges exceeding the health care provider's usual and customary charge) inapplicable to the reimbursement calculation. Rule 133.20(e) helps to minimize costs to employees and insurance carriers under §408.028(f).

Agency Response: The Division declines to make the recommended change. As already stated, the Division has removed "usual and customary charge" from this fee guideline due to the legislative directive in HB 528. The reason for the exclusion of §133.20(e)(1) in the proposed and adopted rule is to ensure there is no conflict between these two sections since the "usual and customary charge" language of §133.20(e)(1) is no longer included in §134.503.

§134.503(d): A commenter recommends the following changes that add the word “generic” to the proposed language: “Reimbursement for nonprescription drugs or over-the-counter medications shall be the retail price of the lowest ‘generic’ package quantity reasonably available.” The commenter recommends the deletion of the proposed language at the end of the subsection that states, “that will fill the prescription.” The recommended language changes are because of concerns regarding the manner in which the proposed rules relate to non-prescription and over-the-counter medications. The commenter asserts that consistent with the treatment of prescription drugs, there should be a specified requirement that generic over brand name medications be used where a generic is readily available.

Agency Response: The Division declines to make the change. The Division notes that adopted rule governs the reimbursement of prescription, non-prescription and over-the-counter alternatives to prescription drugs and that §134.502 of this title (relating to Pharmaceutical Services) provide guidance to doctors regarding the prescription of over-the-counter alternatives to prescription drugs. Additionally, the Division is unaware of any specific problems regarding the use and reimbursement of over-the-counter alternatives to prescription drugs, and suggests that the use of over-the-counter drugs is not a significant cost driver in the Texas workers' compensation system. Although costs are a consideration, the administrative burden to establish and implement a new, more explicit and demanding process for injured employees and health care providers to obtain over-the-counter alternatives to prescription drugs is potentially a cost increase to the system rather than a savings. Further, complicating the purchase and reimbursement of over-the-counter alternatives could potentially encourage the use of prescription drugs rather than the less expensive over-the-counter alternative, which would negate the legislative intent of allowing clinically appropriate over-the-

counter alternatives to prescription drugs as a cost-savings measure in the Texas workers' compensation system.

§134.503(f): A commenter supports the ability to contract for amounts different from the fee schedule as stated in subsection (f) of the proposed rule.

Agency Response: The Division appreciates the supportive comment.

§134.503(f): Commenters suggest that additional clarification is needed that the contract has to be between the person paying the bill and the person submitting the bill. A commenter states, "We get concerned when one of our members is a third-party biller and they get bills in, and then suddenly they're getting subjected to contract rates, and they didn't sign a contract."

Agency Response: The Division disagrees. HB 528 sets out when pharmacy reimbursement may be made pursuant to a contract. Labor Code §408.0281(c) authorizes an insurance carrier to pay a health care provider fees for pharmaceutical services that are inconsistent with fee guidelines adopted by the Commissioner only if the insurance carrier has a contractual relationship with the health care provider and that contract includes a specific fee schedule. HB 528 also allows insurance carriers or their authorized agents to use informal and voluntary networks to obtain these contracts with health care providers. Accordingly, if there is a contractual relationship between the insurance carrier and the health care provider that complies with HB 528, HB 528 permits the insurance carrier to reimburse at the contracted rate. Neither the insurance carrier nor the health care provider can nullify their contractual relationship because the health care provider decides to use a processing agent.

§134.503(f): A commenter states that they have contacted insurance carriers and their contracted PBMs in an attempt to comply with the electronic billing rules. The commenter states that the

responses from the PBMs have consistently stated that the pharmacy must enter into a discounted network pharmacy contract. The commenter states that in their review of §133.501 of this title, there does not appear to be any sections allowing insurance carriers and PBMs to enforce their contracted rates or force a non-network pharmacy to sign their contract: only that they accept the Division's standard of the NCPDP 5.1. The commenter recommends further clarification on the rules adopted for the electronic submission of pharmacy bills.

Agency Response: This comment concerns the application of the Division's electronic billing rules, and is outside the scope of these adopted rules. As always, the Division encourages parties to file complaints with the Division if they believe another party is violating the Act or Division rules.

§134.503(g)(1) and (2): A commenter raises concerns with the substitution of "health care provider" for "pharmacist" relating to the dispensing of drugs as physician dispensing of drugs in workers' compensation has been a major problem in many states, and the Texas Legislature just recently rejected a bill that would permit physicians to directly dispense drugs under limited circumstances. The word "pharmacist" is recommended to be retained in the rule to prevent any ambiguity regarding physician dispensing, and so that it is clearly understood that only pharmacists should be allowed to dispense medications.

Agency Response: The Division disagrees that the adopted language is ambiguous. The statutes and rules governing physician dispensing of drugs are fully addressed by the Medical Practice Act and Pharmacy Act under the Occupations Code and related Medical Board rules regarding the authority of physicians to supply drugs. The term "health care provider" also conforms to Division nomenclature. This rule is not intended to allow the dispensing of drugs outside of what currently is permissible under the Medical Practice Act and the Pharmacy Act under the Occupations Code, and limited by the health care provider's license and scope of practice.

Additionally, the commenter's issues were raised and addressed in the rulemaking process for the Division's recently adopted pharmacy closed formulary rules, and consequently these proposed changes in subsection (g) of this section are conforming changes for consistently applied terminology throughout Chapter 133 Subchapter F.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE SECTIONS.

For: Healthesystems and Injured Workers' Pharmacy.

For, with changes: American Insurance Association, Insurance Council of Texas, Progressive Medical, Inc., Property Casualty Insurers Association of America, StoneRiver Pharmacy Solutions, Texas Mutual Insurance Company, and Workers' Compensation Pharmacy Alliance.

Against: None.

Neither for or Against: None.

6. STATUTORY AUTHORITY.

These rule amendments are adopted under the Labor Code §§408.028, 408.0281, 408.027, 401.011, 402.021, 408.021, 413.0111, 402.00111, 402.00116, 402.00128, 402.061, and 504.053; and Insurance Code Chapter 1305.

The Labor Code §408.028(e) requires the Commissioner by rule to allow an employee to purchase a brand name drug rather than a generic pharmaceutical medication or over-the-counter alternative to a prescription medication if a health care provider prescribes a generic pharmaceutical or an over-the-counter alternative to a prescription medication. The injured employee shall be responsible for paying the difference between the cost of the brand name drug and the cost of the generic or over-the-counter alternative to a prescription medication. The injured employee may not seek reimbursement for the difference in cost from an insurance carrier and is not entitled to use the

medical dispute resolution provisions of Labor Code Chapter 413 with regard to the prescription.

The Labor Code §408.028(f) requires the Commissioner by rule to adopt a fee schedule for pharmacy and pharmaceutical services that will provide reimbursement rates that are fair and reasonable; assure adequate access to medications and services for injured employees, minimize costs to employees and insurance carriers and take into consideration the increased security of payment afforded by this subtitle. The Labor Code §408.028(g) provides that the Labor Code §413.011(d) and the rules adopted to implement that subsection do not apply to the fee schedule adopted by the Commissioner under the Labor Code §408.028(f).

HB 528 amends the Labor Code by adding §408.0281 (relating to Reimbursement for Pharmaceutical Services; Administrative Violation). Section 408.0281(b) sets forth that notwithstanding any provision of the Insurance Code Chapter 1305 (relating to Workers' Compensation Health Care Networks) or the Labor Code §504.053 (relating to Election), prescription medication or services, as defined by §401.011(19)(E), may be reimbursed in accordance with the fee guidelines adopted by the Commissioner or at a contract rate in accordance with this section. Section 408.0281(b)(2) also provides that prescription medication or services may not be delivered through a workers' compensation health care network under Insurance Code Chapter 1305, or a contract concerning workers' compensation insurance coverage for employees of political subdivisions as described by the Labor Code §504.053(b)(2). Under the Labor Code §408.0281(c), HB 528 authorizes the reimbursement of prescription medication or services that is inconsistent from the fee guidelines the Commissioner adopts only if the insurance carrier has a contract with the health care provider and that contract includes a specific fee schedule. An insurance carrier or the carrier's authorized agent may use an informal or voluntary network to obtain a contractual

agreement that provides for fees different from the fees authorized under the fee guidelines adopted by the Commissioner for pharmaceutical services.

The Labor Code §408.027(f) provides that except for the Labor Code §408.0281, any payment made by an insurance carrier to a health care provider under §408.027 shall be in accordance with the fee guidelines authorized under the Act, if the health care service is not provided through a workers' compensation health care network under Insurance Code Chapter 1305 or at a contracted rate for that health care service if the health care service is provided through a workers' compensation health care network under Insurance Code Chapter 1305.

The Labor Code §401.011 contains definitions used in the Texas workers' compensation system (in particular, §401.011(19)(E), the definition of "health care," which includes a prescription drug, medicine or other remedy, §401.011(22), the definition of "health care provider," and §401.011(22-a), the definition of "health care reasonably required").

The Labor Code §402.021 states that the workers' compensation system of this state must provide timely, appropriate, and high-quality medical care supporting restoration of the injured employee's physical condition and earning capacity.

The Labor Code §408.021 states that an injured employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed.

The Labor Code §413.0111 requires that a rule on reimbursement of prescription medication or services must authorize pharmacies to use agents or assignees to process claims and act on behalf of pharmacies.

The Labor Code §402.00111 provides that the Commissioner shall exercise all executive authority, including rulemaking authority, under the Labor Code and other laws of this state. Section

402.00116 grants the powers and duties of chief executive and administrative officer to the Commissioner and the authority to enforce Labor Code Title 5, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to the Division or Commissioner. Section 402.00128 provides general operational powers to the Commissioner to conduct daily operations of the Division and implement Division policy including the duty to delegate, assess and enforce penalties and enter appropriate orders as authorized by Labor Code Title 5. Section 402.061 provides the Commissioner the authority to adopt rules as necessary to implement and enforce the Act. Section 413.0511 requires that the Medical Advisor must make recommendations regarding the adoption of rules and policies concerning health care.

The Labor Code §504.053(b)(2) provides that if a political subdivision or a pool determines that a workers' compensation health care network certified under Insurance Code Chapter 1305, is not available or practical for the political subdivision or a pool, it may provide medical benefits to its injured employees by directly contracting with health care providers or by contracting through a health benefits pool established under the Local Government Code Chapter 172.

Insurance Code Chapter 1305 is the Workers' Compensation Health Care Network Act that authorizes the establishment of certified networks for the provision of workers' compensation medical benefits. In particular, §1305.101(c) sets forth that prescription medication and services may not directly or through a contract be delivered through a workers' compensation health care network and that prescription medication and services shall be reimbursed as provided by the Labor Code §408.0281, other provisions of the Act and applicable rules of the Commissioner.

7. TEXT.

§134.503. Pharmacy Fee Guideline.

(a) Applicability of this section is as follows:

(1) This section applies to the reimbursement of prescription drugs and nonprescription drugs or over-the-counter medications as those terms are defined in §134.500 of this title (relating to Definitions) for outpatient use in the Texas workers' compensation system, which includes claims:

(A) subject to a certified workers' compensation health care network as defined in §134.500 of this title;

(B) not subject to a certified workers' compensation health care network; and

(C) subject to Labor Code §504.053(b)(2).

(2) This section does not apply to parenteral drugs.

(b) For coding, billing, reporting, and reimbursement of prescription drugs and nonprescription drugs or over-the-counter medications, Texas workers' compensation system participants shall apply the provisions of Chapters 133 and 134 of this title (relating to General Medical Provisions and Benefits--Guidelines for Medical Services, Charges, and Payments, respectively).

(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.

(d) Reimbursement for nonprescription drugs or over-the-counter medications shall be the retail price of the lowest package quantity reasonably available that will fill the prescription.

(e) Except as provided by subsection (f) of this section, if an amount cannot be determined in accordance with subsections (c)(1) or (d) of this section, reimbursement shall be an amount that is consistent with the criteria listed in Labor Code §408.028(f), including providing for reimbursement rates that are fair and reasonable. The insurance carrier shall:

(1) develop a reimbursement methodology(ies) for determining reimbursement under this subsection;

(2) maintain in reproducible format documentation of the insurance carrier's methodology(ies) for establishing an amount;

(3) apply the reimbursement methodology(ies) consistently among health care providers in determining reimbursements under this subsection; and

(4) upon request by the division, provide to the division copies of such documentation.

(f) Notwithstanding the provisions of this section, prescription medication or services, as defined by Labor Code §401.011(19)(E), may be reimbursed at a contract rate that is inconsistent with the fee guideline as long as the contract complies with the provisions of Labor Code §408.0281 and applicable division rules.

(g) When the prescribing doctor has written a prescription for a generic drug or a prescription that does not require the use of a brand name drug in accordance with §134.502(a)(3) of this title (relating to Pharmaceutical Services), reimbursement shall be as follows:

(1) the health care provider shall dispense the generic drug as prescribed and shall be reimbursed the fee established for the generic drug in accordance with subsection (c) or (f) of this section; or

(2) when an injured employee chooses to receive a brand name drug instead of the prescribed generic drug, the health care provider shall dispense the brand name drug as requested and shall be reimbursed:

(A) by the insurance carrier, the fee established for the prescribed generic drug in accordance with subsection (c) or (f) of this section; and

(B) by the injured employee, the cost difference between the fee established for the generic drug in subsection (c) or (f) of this section and the fee established for the brand name drug in accordance with subsection (c) or (f) of this section.

(h) When the prescribing doctor has written a prescription for a brand name drug in accordance with §134.502(a)(3) of this title, reimbursement shall be in accordance with subsection (c) or (f) of this section.

(i) Upon request by the health care provider or the division, the insurance carrier shall disclose the source of the nationally recognized pricing reference used to calculate the reimbursement.

(j) Where any provision of this section is determined by a court of competent jurisdiction to be inconsistent with any statutes of this state, or to be unconstitutional, the remaining provisions of this section shall remain in effect.

§134.504. Pharmaceutical Expenses Incurred by the Injured Employee.

(a) It may become necessary for an injured employee to purchase prescription drugs or over-the-counter alternatives to prescription drugs prescribed or ordered by the treating doctor or referral health care provider. In such instances the injured employee may request reimbursement from the insurance carrier as follows:

(1) The injured employee shall submit to the insurance carrier a letter requesting reimbursement along with a receipt indicating the amount paid and documentation concerning the prescription. The letter should include information to clearly identify the claimant such as the claimant's name, address, date of injury, and social security number. Documentation for prescription drugs submitted with the letter from the employee must include the prescribing health care provider's name, the date the prescription was filled, the name of the drug, employee's name and dollar amount paid by the employee. As examples, this information may be provided on an information sheet provided by the pharmacy, or the employee can ask the pharmacist for a print out of work related prescriptions for a particular time period. Cash register receipts alone are not acceptable.

(2) The insurance carrier shall make appropriate payment to the injured employee in accordance with §134.503, or notify the injured employee of a reduction or denial of the payment within 45 days of receipt of the request for reimbursement from the injured employee. If the

insurance carrier does not reimburse the full amount requested, or denies payment the carrier shall include a full and complete explanation of the reason(s) the insurance carrier reduced or denied the payment and shall inform the injured employee of his or her right to request medical dispute resolution in accordance with §133.305 of this title (relating to Medical Dispute Resolution). The statement shall include sufficient claim-specific substantive information to enable the employee to understand the insurance carrier's position and/or action on the claim. A general statement that simply states the carrier's position with a phrase such as "not entitled to reimbursement" or a similar phrase with no further description of the factual basis does not satisfy the requirements of this section.

(b) An injured employee may choose to receive a brand name drug rather than a generic drug or over-the-counter alternative to a prescription medication that is prescribed by a health care provider. In such instances, the injured employee shall pay the difference in cost between generic drugs and brand name drugs. The transaction between the employee and the pharmacist is considered final and is not subject to medical dispute resolution by the division. In addition, the employee is not entitled to reimbursement from the insurance carrier for the difference in cost between generic and brand name drugs.

(1) The injured employee shall notify the pharmacist of their choice to pay the cost difference between generic and brand name drugs. An employee's payment of the cost difference constitutes an acceptance of the responsibility for the cost difference and an agreement not to seek reimbursement from the carrier for the cost difference.

(2) The pharmacist shall:

(A) determine the costs of both the brand name and generic drugs under §134.503 of this title, and notify the injured employee of the cost difference amount;

(B) collect the cost difference amount from the injured employee in a form and manner that is acceptable to both parties;

(C) submit a bill to the insurance carrier for the generic drug that was prescribed by the doctor; and

(D) not bill the injured employee for the cost of the generic drug if the insurance carrier reduces or denies the bill.

(3) The insurance carrier shall review and process the bill from the pharmacist in accordance with Chapter 133 and 134 (pertaining to General Medical Provisions and Benefits-Guidelines for Medical Services, Charges, and Payment, respectively).

8. CERTIFICATION.

This agency hereby certifies that the adopted amendments have been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued at Austin, Texas, on _____, 2011.

X

Dirk Johnson
General Counsel
Texas Department of Insurance,
Division of Workers' Compensation

IT IS THEREFORE THE ORDER of the Commissioner of Workers' Compensation that the amendments to §134.503 specified herein, concerning the Pharmacy Fee Guideline, and the amendments to §134.504 specified herein, concerning the Pharmaceutical Expenses Incurred by the Injured Employee, are adopted.

AND IT IS SO ORDERED.

X

ROD BORDELON
COMMISSIONER OF WORKERS' COMPENSATION

ATTEST:

X

Dirk Johnson
General Counsel

COMMISSIONER ORDER NO.