



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

ProximaRX

Respondent Name

Zurich American Insurance Co

MFDR Tracking Number

M4-24-2459-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

July 4, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 18, 2024	00536-1202-15	\$86.66	\$32.20
		\$86.66	\$32.20

Requestor's Position

"I have attached the EOBs as well as the documentation to prove that ProximaRX has met the requirements to receive reimbursement."

Amount in Dispute: \$86.66

Respondent's Position

"We will provide a supplemental response once the bill auditing company has finalized their review."

Response submitted by: Gallagher Bassett

Supplemental response submitted by Gallagher Bassett August 29, 2024, "Our bill audit company has determined additional monies are owed in the amount of \$86.66. Interest in the amount of \$3.09 has been added. Attached are an updated copy of the Explanation of Benefits and payment summaries for your records."

Findings and Decision

Authority

This medical fee dispute is decided according to [Texas Labor Code §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.530](#) sets out the requirements of prior authorization.
3. [28 TAC §134.503](#) sets out the fee guidelines for pharmacy services.

Denial Reasons

- 197 – Precertification/authorization/notification/pre-treatment absent.
- 70 – Drug not on formulary

Issues

1. Did the respondent support payment was made?
2. Was prior authorization required?
3. What rule(s) apply to disputed services?

Findings

1. The respondent supplemented their position to MFDR with the statement, "Our bill audit company has determined additional monies are owed in the amount of \$86.66. Interest in the amount of \$3.09 has been added. Attached are an updated copy of the Explanation of Benefits and payment summaries for your records." Review of the submitted documents does not support a payment being made. The disputed service will be reviewed per applicable DWC Rule.
2. The requestor is seeking reimbursement for medication dispensed on January 18, 2024. The insurance carrier denied the medication as seen above.

DWC Rule 28 TAC §134.530 (b)(1)(A) states in pertinent part, "Preauthorization is only required for drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A."

Review of the applicable Appendix A found this medication (Lidocaine Pain Relief 4%) is not listed as a "N" drug. The respondents' denial is not supported.

The service in dispute will be reviewed per applicable fee guideline.

3. DWC Rule 28 Texas Administrative Code §134.503 (c)(1)(A)(B) states in pertinent part (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for

prescription drugs the lesser of:

(1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:

(A) Generic drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.09) + \4.00 dispensing fee per prescription = reimbursement amount;

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Lidocaine Patch 4%	00536120215	G	1.50	15	\$32.20	\$86.66	\$32.20

The total reimbursement is \$32.20, this amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that Zurich American Insurance Co must remit to ProximaRX \$32.20 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

November 22, 2024
Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel*

a *Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in [28 TAC §141.1\(d\)](#).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.