



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

ProximaRX

**Respondent Name**

XL Insurance America Inc

**MFDR Tracking Number**

M4-24-2847-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

August 23, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 26, 2024	65162-0918-38	\$357.50	\$357.50
		\$357.50	\$357.50

### Requestor's Position

"Changing the denial prevents the health care provider to properly provide a rationale. The denial should be accompanied by the original bill, a copy of the first EOB, and a letter of rationale."

**Amount in Dispute:** \$357.50

### Respondent's Position

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

**Response submitted by:** Gallagher Bassett

### 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 §134.503](#) sets out the fee guidelines for pharmacy services.

## Denial Reasons

- 109-1/90147 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- 193/ 90563 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- ZK10 – Resolution Manager denial

## Issues

1. Is the insurance carrier's denial supported?
2. What rule(s) apply to disputed services?

## **Findings**

1. The requestor is seeking reimbursement for the medication Lidocaine Oin 5% dispensed on March 26, 2024. The insurance carrier denied the medication as seen above.

Review of the submitted documentation found insufficient evidence to support this medication is not covered by this contractor or that a denial from the resolution manager was made.

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

2. 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	65162091838	G	8.46	35	\$374.34	\$357.50	\$357.50

The total reimbursement is \$357.50, 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 additional 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 XL Insurance America Insurance Inc must remit to ProximaRX \$357.50 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 27, 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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).