TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
ProximaRx

Respondent Name
Technology Insurance Company Inc

MFDR Tracking Number
M4-24-2869-01

Carrier's Austin Representative
Rep Box 17

DWC Date Received
August 23, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 7, 2024	NDC # 65162-0918-38	$357.50	$357.50

Requestor's Position

"The explanation of benefits indicates that carrier paid $30.00 and not the full amount of $499.77. This claim should be processed with the full amount billed as per Administrative Labor Code 134.503(c)."

Amount in Dispute: $357.50

Respondent's Position

"Respondent denied payment for the prescription of Lidocaine ointment 5% for lack of utilization review of the medication. Currently, only Lidocaine 5% patches (brand name Lidoderm) and 1.8% patches (brand name ZTlido) are Y drugs and are the only two forms of Lidocaine included on Appendix A. The ODG helpdesk confirmed these two forms."
Response Submitted by: Down & Stanford, P.C.

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 Texas Administrative Code §133.305 sets out the general procedures for medical dispute resolution.

2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

3. 28 TAC §134.503 sets out the fee guidelines for pharmacy.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- VPUR – Denied for UR
- D2 (P12) – The charge for the over-the-counter medication exceeds the retail price.
- D3 (P12) – The charge for the prescription drug is greater than the maximum reimbursement for a generic drug.

Issues

1. Did the insurance carrier support the denial reason code VPUR?

2. Is insurance carrier's denial reason(s) supported?

3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier in their position summary states, "Respondent denied payment for the prescription of Lidocaine ointment 5% for lack of utilization review of the medication."

   DWC Rule 28 TAC §137.100 (e) states, "An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017."

Retrospective utilization review is defined in 28 TAC §19.2003 (b)(31) as, "A form of utilization review for health care services that have been provided to an injured employee. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted."

Additionally, 28 TAC §133.240 (q) states, in relevant part, "When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title and when the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title …, including the requirement that prior 3 to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor ..."

A review of the submitted documentation does not support that the insurance carrier followed the appropriate procedures for a retrospective review denial of the disputed services outlined in §19.2003 (b)(31) or §133.240 (q). The DWC finds that the insurance carrier did not appropriately raise medical necessity for this dispute, and therefore the disputed service is reviewed pursuant to the applicable rules and guidelines.

2. The requestor is seeking reimbursement in the amount of $357.50 for prescription dispensed on March 7, 2024. The insurance carrier is denying reimbursement due to the denial reasons indicated above.

   Based on the documentation provided, DWC finds that the carrier failed to sufficiently support the denial for reimbursement. The requestor is therefore entitled to reimbursement for the medications in dispute.

3. 28 TAC §134.503 (c) states the insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of 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:

   - Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $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 Amt
Lidocaine 5%	65162091838	G	8.46	35	$374.34	$357.50	$357.50
				TOTAL	$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 reimbursement of $357.50 is due.

Order

Pursuant to the Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $357.50 reimbursement. DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that respondent must remit to the requestor $357.50 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		October 21, 2024
Signature	Medical Fee Dispute Resolution Officer	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, 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 electronico CompConnection@tdi.texas.gov.