TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
ProximaRx

Respondent Name
Technology Insurance Company Inc

MFDR Tracking Number
M4-24-2870-01

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
April 30, 2024	NDC # 65162-0918-38	$357.50	$357.50

Requestor's Position

"The original claim was denied for PRODUCT/SERVICE NOT COVERED. An appeal was submitted to and received by the carrier on 07/05/2024. The appeal was denied by the carrier. The carrier cited new denial reasons under PARTIAL PAYMENT."

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."

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:

- HE70 – Product / service not covered.

Issues

1. Did the insurance carrier raise new denial reasons or defenses?

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.

   A review of the insurance carrier's response finds a new denial reason or defense raised that was not presented to the requestor before the filing of the request for medical fee dispute resolution.

   Rule §133.307(d)(2)(B) requires that upon receipt of the request for medical fee dispute resolution, the respondent shall provide any missing information not provided by the requestor and known to the respondent, including: a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider… related to the health care in dispute not submitted by the requestor or a statement certifying that the respondent did not receive the health care provider's disputed billing prior to the dispute request.

A review of the submitted information finds insufficient documentation to support an EOB was presented to the health care provider giving notice of the UR decision, raised in the insurance carrier's response to MFDR.

Rule §133.307(d)(2)(F) requires that: The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

Pursuant to Rule §133.307(d)(2)(F), the insurance carriers failed to give notice to the health care provider of specific codes or explanations for reduction or denial of payment as required by Rule §133.240.

The DWC finds the respondent has raised new denial reasons or defenses. The carrier failed to give notice to the health care provider during the medical bill review process or before the filing of this dispute. The division concludes that the insurance carrier has waived the right to raise a new denial reason or defense during dispute resolution. Any such new defenses or denial reasons will not be considered in this review.

2. The requestor is seeking reimbursement in the amount of $357.50 for a prescription dispensed on April 30, 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 requestor seeks $357.50; therefore, 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 is entitled to reimbursement of $357.50.

Order

Pursuant to the 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 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 29, 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.