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
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-24-2887-01

Carrier's Austin Representative
Rep Box 15

DWC Date Received
August 23, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 11, 2024	NDC # 63304-0693-01	$131.84	$96.93
January 11, 2024	NDC # 59651-0361-05	$89.14	$43.56
	Total	$220.98	$140.49

Requestor's Position

"The carrier denied the bill based on LACK OF PREAUTHORIZATION."

Amount in Dispute: $220.98

Respondent's Position

"The rationale for this determination is found below. DOS: 01/11/2024 - 01/11/2024 Rationale: No authorization for the medication."

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 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:

- 00663 - Reimbursement has been calculated according to state fee schedule guidelines
- 193 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 197 - Payment denied/reduced for absence of precertification/authorization.
- 5283 - Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract, or carrier decision.
- 5725 - First Script has denied the line for utilization.
- 90563 - Original payment decision is being maintained. upon review, it was determined that this claim was processed properly.
- 93 - No claim level adjustment
- P12 - Workers' compensation jurisdictional fee schedule adjustment.
- 90147, 109 - Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- 5721 - To avoid duplicate bill denial, for all reconsiderations/ adjustments/ additional payment requests, submit a copy of this EOR or clear notation that a recon is
- ZK10 - Resolution Manager Denial
- P6 - Based on entitlement to benefits.

Issues

1. Does the dispute contain unresolved compensability, extent of injury, and/or liability (CEL) issues?

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

3. Is the requestor entitled to additional reimbursement?

Findings

1. Documentation provided by the parties indicates that the insurance carrier denied payment due to an unresolved compensability, extent of injury, and/or liability issues for dispensed medications, January 11, 2024.

   A review of the documentation submitted by the parties finds that the carrier did not provided documentation to the Division to support that it filed a Plain Language Notice (PLN) regarding the disputed conditions as required by §133.307(d)(2)(H).

   The respondent did not submit information to MFDR, sufficient to support that the PLN had ever been presented to the requestor or that the requestor had otherwise been informed of PLN prior to the date that the request for medical fee dispute resolution was filed with the DWC; therefore, the DWC finds that the CEL denial was not timely presented to the requestor in the manner required by 28 TAC §133.240. Because the service in dispute does not contain an unresolved CEL issue, this matter is eligible for adjudication of a medical fee under 28 TAC §133.307. For that reason, this matter is addressed pursuant to the applicable rules and guidelines

2. The requestor is seeking reimbursement in the amount of $220.98 for medications dispensed on January 11, 2024. The insurance carrier is denying reimbursement due to the denial reasons indicated above.

   The submitted documentation indicates that the insurance carrier denied the disputed drugs based on preauthorization. Preauthorization is only required for:

   - drugs identified with a status of "N" in the current edition of the ODG Appendix A
   - any compound prescribed before July 1, 2018, that contains a drug identified with a status of "N" in the current edition of the ODG Appendix A
   - any prescription drug created through compounding prescribed and dispensed on or after July 1, 2018; and
   - any investigational or experimental drug.

   The DWC finds that the drugs in question are identified with a status of "Y" in the applicable edition of the ODG, Appendix A. Therefore, these drugs do not require preauthorization for this reason. The DWC concludes that the insurance carrier's denial of payment of the disputed drugs based on preauthorization is not supported.

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
Clindamycin HCl	63304069301	G	3.717	20	$96.93	$131.84	$96.93
Ibuprofen 600 mg	59651036105	G	0.527	60	$43.56	$89.14	$43.56
				TOTAL	$140.49	$220.98	$140.49

The total reimbursement is $140.49. 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 $140.49 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 respondent must remit to the requestor $140.49 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	October 30, 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, 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.