



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

ProximaRX

**Respondent Name**

Transportation Insurance Co

**MFDR Tracking Number**

M4-24-2895-01

**Carrier's Austin Representative**

Box Number 57

**DWC Date Received**

August 24, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 19, 2023	71093-0121-05	\$137.30	\$103.75
		\$137.30	\$103.75

### Requestor's Position

"The carrier denied the bill based on **LACK OF PREAUTHORIZATION**. These medications do not require preauthorization therefore do not need a retrospective review."

**Amount in Dispute:** \$137.30

### Respondent's Position

"Carrier has forwarded this to our bill review vendor, Conduent, to be reaudited. To date, Carrier has not received a response for the URA regarding this matter. At this time, Carrier maintains any and all denials as represented in the EORs.

**Response submitted by:** Law Office of Brian J. Judis

### 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 – Payment denied/reduced for absence of precertification/authorization.
- 5026 – First Script has denied the line for utilization.

## Issues

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

## **Findings**

1. The requestor is seeking reimbursement for medication dispensed on December 19, 2023. 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 Gabapentin Cap is not listed as a "N" drug. The insurance carrier's denial is not supported.

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: ((AWP per unit) x (number of units) x 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
Gabapentin	71093012105	G	1.33	60	\$103.75	\$137.30	\$103.75

3. The total reimbursement is \$103.75, 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 Transportation Insurance Co must remit to ProximaRX \$103.75 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).