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

General Information

Requestor Name
ProximaRX

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-24-2970-01

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
December 6, 2023	65162-0918-38	$357.50	$14.58
		$357.50	$14.58

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

"The carrier is continuing to review this matter and will supplement this response."

Response submitted by: Flahive, Ogden & Latson

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

- SMOI – Missing or invalid physician/provider ID. Need valid NPI, DEA and/or NCPCP number.

Issues

1. Is the insurance carrier's denial supported?
2. Is the number of units submitted supported?
3. What rule is applicable to reimbursement?
4. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement of the medication (Lidocaine Oin 5%) for date of service December 6, 2023. The insurance carrier denied the claim for missing information. Review of the submitted medical bill found the carrier accepted the other medication (Ibuprofen) submitted on the same DWC066 dated December 8, 2023. The insurance carrier's reason for not processing the medication in dispute is not supported. The service in dispute will be reviewed per applicable fee guideline.
2. Review of the submitted DWC066 for the date of service December 6, 2023, was for the following medication. Lidocaine Ointment 5%.

   Review of the NDC description for 65162-0918-38 is as follows.

Dosage Form	Package Size	Package Size Unit of Measure	Package Quantity	Total Package Quantity	Package Description	Metric Strength	Strength Unit of Measure
OINT	35.440	GM	1	35.440	TUBE	5.00000	

   Based on the above the correct number of units is one tube not thirty-five, which is the number of grams included in the one tube. The number of units considered in this review is one.

3. 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: ((AWP per unit) x (number of units) x 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
Lidocaine 5%	65162091838	G	$8.465	1	$14.58	$357.50	$14.58

4. The total reimbursement is $14.58, 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 American Zurich Insurance Co must remit to ProximaRX $14.58 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	December 5, 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, please 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.