



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

ProximaRx

Respondent Name

American Zurich Insurance Co

MFDR Tracking Number

M4-24-2998-01

Carrier's Austin Representative

Rep Box 19

DWC Date Received

August 30, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 12, 2024	NDC # 65162-0918-38	\$357.50	\$357.50

Requestor's Position

"The above claimant received medication as prescribed by the referral provider. Bill for date of service 01/12/2024 still has not been processed by carrier. All bills are required to be processed within 45 days of receipt by the carrier as per Texas Labor Code 408.027(b). ProximaRX has not received any correspondence with explanation of review or benefits."

Amount in Dispute: \$357.50

Respondent's Position

"The Respondent maintains that the provider is not entitled to additional reimbursement for the Lidocaine ointment as the denial is valid under Texas Workers' Compensation regulations, specifically due to the lack of preauthorization and the proper application of fee schedule adjustments. The denial was reaffirmed during the review and reconsideration processes, with no new evidence to support the reversal of the decision."

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 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:

- Explanation of review or benefits (EOR/EOB) not provided by either party.

Issues

1. Is the insurance carrier's denial reason(s) supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement in the amount of \$357.50 for medication(s) dispensed on January 12, 2024. The insurance carrier is denying reimbursement, however, did not provide a copy of the EOR or EOB for verification of denial reasons.

Pursuant to 28 TAC §133.307 (d)(2)(B), "Responses to a request for MFDR must be legible and submitted to the division and to the requestor in the form and manner prescribed by the division. (2) Response. On receipt of the request, the respondent must provide any missing information not provided by the requestor and known to the respondent. The respondent must also provide the following information and records... (B) all initial and appeal EOBs related to the dispute as originally submitted to the health care provider in accordance with this chapter, related to the health care in dispute not submitted by the requester, or a statement certifying that the respondent did not receive the health care provider's disputed billing before the dispute request."

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.

2. 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: $((\text{AWP per unit}) \times (\text{number of units}) \times 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 Ointment 5%	65162091838	G	8.46	35	\$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 requestor has established that reimbursement of \$357.50 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 \$357.50 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 1, 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 electrónico CompConnection@tdi.texas.gov.