



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

ProximaRx

**Respondent Name**

New Hampshire Insurance Co

**MFDR Tracking Number**

M4-25-0011-01

**Carrier's Austin Representative**

Rep Box 19

**DWC Date Received**

September 4, 2024

### Summary of Findings

| Dates of Service | Disputed Services   | Amount in Dispute | Amount Due      |
|------------------|---------------------|-------------------|-----------------|
| March 12, 2024   | NDC # 43598-0977-10 | \$77.81           | \$21.98         |
| March 12, 2024   | NDC # 50228-0178-05 | \$240.47          | \$232.71        |
| <b>Total</b>     |                     | <b>\$318.28</b>   | <b>\$254.69</b> |

### Requestor's Position

"The original claim was denied for PARTIAL PAYMENT. An appeal was submitted to and received by the carrier on 03/22/2024. The appeal was denied by the carrier."

**Amount in Dispute:** \$318.28

### Respondent's Position

The Austin carrier representative for New Hampshire Insurance Company is Flahive, Ogden and Latson. Flahive, Ogden and Latson was notified of this medical fee dispute on September 10, 2024. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

# 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.
4. [28 Texas Administrative Codes §§134.530](#) and [134.540](#) sets out the closed formulary requirements, effective January 17, 2011, 35 TexReg 11344.

## **Denial Reasons**

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 70 – Drug not on formulary.
- 197 -Precertification/authorization/notification/pre-treatment absent.
- 18 – Exact duplicate claim/service.
- 75 – Prior authorization required.
- 85 – Claim not processed.
- 83 – Claim previously processed.

## **Issues**

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

## **Findings**

1. ProximaRx is seeking reimbursement for medications dispensed March 12, 2024.

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 drug based on preauthorization is not supported.

2. The DWC concludes that the disputed medications rendered on March 12, 2024, are identified as "Y" status drugs. As a result, pre-authorization was not required. Because the insurance carrier's denial reason was not supported reimbursement is recommended.

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 |
|-------------------|-------------|-----------------------|--------------|--------------|-------------|------------|------------------------------|
| Diclofenac Gel 1% | 43598097710 | G                     | 0.14380      | 100          | \$21.98     | \$77.81    | \$21.98                      |
| Gabapentin        | 50228017805 | G                     | 3.04950      | 60           | \$232.71    | \$240.47   | \$232.71                     |
| TOTAL             |             |                       |              |              | \$254.69    | \$318.28   | \$254.69                     |

The total reimbursement is \$254.69. 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 \$254.69 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 \$254.69 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 12, 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, 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).