



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

ProximaRx

Respondent Name

AIU Insurance Co

MFDR Tracking Number

M4-25-0020-01

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
February 5, 2024	NDC # 49483-0699-01 Acetaminophen ER	\$72.18	\$15.48
February 5, 2024	NDC # 71093-0120-05 Gabapentin	\$73.40	\$23.88
Total		\$145.58	\$39.36

Requestor's Position

"The original claim was denied for PARTIAL PAYMENT. An appeal was submitted to and received by the carrier on 02/09/2024. The appeal was denied by the carrier. The carrier cited new denial reasons under TIMELY FILING. See attached 2 denials for processing. There were not any additional code changes or services rendered. Therefore, the carrier cannot change from the original denial. A provider must be able to address the bill properly for continued care."

Amount in Dispute: \$145.58

Respondents' Position

The Austin carrier representative for AIU Insurance is Flahive, Ogden & Latson who 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 (TAC) §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 TAC §§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:

- 60(B13) – The provider billed for the exact services on a previous bill.
- XD(P12) – This bill was submitted after the billing timeliness guidelines provided.
- ZR(P12) – The provider or a different provider has billed for the exact service on a previous bill where no allowance was originally recommended.
- D3(P12) – The charge for the prescription drug is greater than the maximum reimbursement for a generic drug.
- HE75 – Prior authorization required to process this bill.
- ZR (P12) – Workers' compensation jurisdictional fee schedule adjustment.

Issues

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

Findings

1. The requestor seeks payment in the amount of \$145.58, for prescriptions Acetaminophen ER and Gabapentin dispensed on February 5, 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. 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
Acetaminophen ER	49483069901	G	0.10200	90	\$15.48	\$72.18	\$15.48
Gabapentin	71093012005	G	0.53000	30	\$23.88	\$73.40	\$23.88
TOTAL					\$39.36	\$145.58	\$39.36

The total reimbursement is \$39.36. 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 \$39.36 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 \$39.36 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 18, 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.