



Medical Fee Dispute Resolution Findings and Decision General Information

Requestor Name

Proximarx

Respondent Name

Union Insurance Co.

MFDR Tracking Number

M4-25-0026-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

September 4, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 11, 2023	Ibuprofen NDC: 59651-0362-05	\$98.60	\$55.38
September 11, 2023	Methocarbamol 500mg NDC: 31722-0533-05	\$86.45	\$40.19
Total		\$185.05	\$95.57

Requestor's Position

"...the carrier allowed \$0.00, denying the bill based on SERVICES NOT PROVIDED BY NETOWORK[sic]/PRIMARY CARE PROVIDERS. Memorial Wellness Pharmacy is an approved and authorized provider and should be reimbursed accordingly."

Amount in Dispute: \$185.05

Respondent's Position

The Austin carrier representative for Union Insurance Co. is Flahive Ogden & Latson. The representative was notified of this medical fee dispute on September 10, 2024. Per 28 Texas Administrative Code §133.307 (d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information. As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Findings and Decision

Authority

This medical fee dispute is decided according to [Texas Labor Code \(TLC\) §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. [28 Texas Administrative Code \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.503](#) sets out the fee guidelines for pharmaceutical services.
3. [TLC 408.021](#) establishes entitlement to medical benefits.
4. [Texas Insurance Code §1305.101](#) defines the duties of networks to provide medical treatment.

Denial Reasons

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

- B1025 - Provider Not Authorized.
- 185 - The rendering provider is not eligible to perform the service billed.
- 341 - The billed amount for drug or supply exceeds Medispan allowance.
- P12 - The provider or a different provider has billed for the exact service on a previous bill where no allowance was originally recommended.
- W3 - TDI Level 1 Appeal means a request for reconsideration under 133.250 of this title or an appeal of an adverse determination under Chapter 19, Subchapter U of this title.
- CIQ377 – Additional recommendation is based upon additional supporting documentation received.

Issues

1. Is the insurance carrier's reason(s) for denial supported?
2. What rules apply to the disputed service?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for prescription medications dispensed on September 11, 2023. The explanation of benefits (EOB) document submitted states the medications were denied because the provider was not authorized to provide the service. This denial reason could indicate either a health care network denial or a lack of preauthorization for the disputed medications.

Regarding a health care network denial, prescription medication may not, directly or through a contract, be delivered through a workers' compensation health care network.

Texas Insurance Code §1305.101 (c) states, "(c) Notwithstanding any other provision of this chapter, prescription medication or services, as defined by Section [401.011](#)(19)(E), Labor Code, may not, directly or through a contract, be delivered through a workers' compensation health care network. Prescription medication and services shall be reimbursed as provided by Section [408.0281](#), Labor Code, other provisions of the Texas Workers' Compensation Act, and applicable rules of the commissioner of workers' compensation."

DWC concludes that the disputed prescription medications dispensed by the provider are not subject to the provisions of a workers' compensation health care network.

Regarding a lack of preauthorization denial, per 28 TAC §134.530 (b)(1) and §134.540 (b), 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.

DWC finds that the drug in question was not identified with a status of "N" in the applicable edition of the ODG, *Appendix A* for the date of service reviewed in this dispute. Therefore, these drugs did not require preauthorization for this reason.

The submitted documentation does not support that the disputed drugs were a compound. Therefore, these drugs did not require preauthorization for this reason.

The submitted documentation does not support that the disputed drugs were experimental or investigational. Therefore, these drugs did not require preauthorization for this reason.

DWC concludes that the insurance carrier's denial of payment of the disputed drugs based on preauthorization is not supported for the date of service in question.

DWC finds that the insurance carrier's denial reason(s) are not supported. Therefore, the requestor is entitled to reimbursement for the medications rendered on September 11, 2023.

2. The service in dispute will be reviewed per applicable fee guideline. DWC Rule 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: $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.25) + \$4.00 \text{ dispensing fee per prescription} = \text{reimbursement amount}$;

3. The requestor seeks reimbursement in the total amount of \$185.05 for prescription medications dispensed on September 11, 2023. Because the insurance carrier failed to support its denial reason(s) for payment of these medications, DWC will adjudicate for the maximum allowable reimbursement (MAR) for the disputed medications in accordance with 28 TAC §134.503(c).

Drug	Number Units Dispensed	NDC	Generic (G)/ Brand (B)	Price/Unit	AWP Formula	Billed Amount	Lesser of AWP and Billed Amount
Ibuprofen 800mg	60	59651-0362-05	G	\$0.68500	\$55.38	\$98.60	\$55.38
Methocarbamol 500mg	60	31722-0533-05	G	\$0.48250	\$40.19	\$86.45	\$40.19
Total					\$95.57	\$185.05	\$95.57

DWC finds that the requestor is entitled to reimbursement for the disputed drugs dispensed on September 11, 2023, in the total amount of \$95.57. Therefore, this amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies on the relevant evidence the requestor and respondent present at the time of adjudication. Although all the evidence in this dispute may not have been discussed, it was considered.

DWC finds the requestor has established that reimbursement is due in the total amount of \$95.57.

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 Union Insurance Co. must remit to Proximarx the amount of \$95.57 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 13, 2024 Date
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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 512-804-4812.