



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

ProximaRX

**Respondent Name**

Federal Insurance Co

**MFDR Tracking Number**

M4-25-0073-01

**Carrier's Austin Representative**

Box Number 17

**DWC Date Received**

September 4, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 10, 2023	43598-0977-10	\$77.81	\$21.98
		\$77.81	\$21.98

### Requestor's Position

"The Request for Reconsideration was submitted to the carrier on **04/05/2024**. The carrier denied the bill based on **LACK OF PREAUTHORIZATION**. These medications do not require preauthorization therefore do not need a retrospective review."

**Amount in Dispute:** \$77.81

### Respondent's Position

"Our supplemental response for the above referenced medical fee dispute resolution is as follows: the bills in question were escalated and a review completed. Our bill audit company has determined no further payment is due. ...No authorization for the medication. Bill Review confirmation that charges were not authorized."

**Response submitted by:** Gallagher Bassett

### 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 §134.530](#) sets out the requirements of prior authorization.
3. [28 TAC §134.503](#) sets out the fee guidelines for pharmacy services.

## Denial Reasons

- 00663 – Reimbursement has been calculated according to state fee schedule guidelines.
- 193/90563 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 4190 – A pharmacist shall dispense no more than a 90-day supply of a prescription medicine.
- 4282 – Drugs identified with a status of "Y" in the current edition of the "Official Disability Guidelines treatment in workers' comp" (ODG/Appendix A. "ODG Workers' compensation drug formulary" identify a drug that can dispensed without preauthorization. The allowance has been determined in according to the pharmacy fee guidelines.
- 5283 – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract, or carrier decision.

## Issues

1. Is the respondents' position supported?
2. What rule(s) apply to disputed services?

## **Findings**

1. The requestor is seeking reimbursement for medication dispensed on November 10, 2023. The insurance carrier states in their position statement, "Bill Review received confirmation that charges were not authorized." DWC Rule 28 TAC §134.530 (b)(1)(A) states in pertinent part, "Preauthorization is only required for drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A."

Review of the applicable Appendix A found this medication (Diclofenac Gel 1%) is not listed as a "N" drug. The respondents' position is not supported. The service in dispute will be reviewed per applicable fee guideline.

2. 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:  $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \$4.00$  dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs:  $((\text{AWP per unit}) \times (\text{number of units}) \times 1.09) + \$4.00$  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
Diclofenac Sodium	43598097710	G	0.143	100	\$21.98	\$77.81	\$21.98

The total reimbursement is \$21.98 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 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 Federal Insurance Co must remit to ProximaRX \$21.98 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 4, 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, please 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).