TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
ProximaRX

Respondent Name
Metropolitan Transit Authority of Harris County

MFDR Tracking Number
M4-24-2839-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 23, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 12, 2024	53746-0109-05	$78.25	$29.93
February 12, 2024	00781-2868-10	$190.96	$9.40
February 12, 2024	29300-0124-10	$152.56	$122.83
		$421.77	$162.16

Requestor's Position

"The carrier denied the original bill as well as the reconsideration based on **(BASED ON FINDINGS OF A REVIEW ORGANIZATION).** ProximaRX did not receive any additional denial codes for the rejection of this bill from the carrier."

Amount in Dispute: $421.77

Respondent's Position

The Austin carrier representative for Metropolitan Transit Authority of Harris County is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on September 4,

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.

Response submitted by: n/a

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 §133.240 sets out the requirements adverse determination notices.
3. Texas Labor Code §19.2010 sets out the utilization review.
4. 28 TAC §134.503 sets out the fee guidelines for pharmacy services.

Denial Reasons

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 216 – Based on the findings of a review organization.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

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

Findings

1. DWC Rule 28 Texas Administrative Code §133.240 (q) states, in relevant part, "When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title ... Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title …, including the requirement that prior to issuance of an adverse determination the insurance

carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor ..." Submitted documentation does not support that the insurance carrier followed the appropriate procedures for a retrospective review denial of the disputed services outlined in §19.2003 (b)(31) or §133.240 (q). Therefore, the insurance carrier did not appropriately raise medical necessity for this dispute and this denial reason will not be considered in this review. The requestor is therefore entitled to reimbursement for the medications in dispute.

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: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs: ((AWP per unit) x (number of units) x 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
Hydrocodone-Apap	53746010905	G	0.69	30	$29.93	$78.25	$29.93
Omeprazole DR	00781286810	G	0.14	30	$9.40	$190.96	$9.40
Meloxicam	29300012410	G	$3.168	30	$122.83	$152.56	$122.83

The total reimbursement is $162.16, 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 additional 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 Metropolitan Transit Authority of Harris County must remit to ProximaRX $162.16 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		November 27, 2024
Signature	Medical Fee Dispute Resolution Officer	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, 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 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.