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
Technology Insurance Company Inc.

MFDR Tracking Number
M4-24-2845-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
August 23, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 22, 2024	Prescription medications	$428.69	$0.00
	Total	$428.69	$0.00

Requestor's Position

"The above claimant received medication as prescribed by the referral provider, however the bill was denied indicating that the date of service occurred after the coverage expired. Bill for date of service 01/22/2024 was created before the date of coverage expiration. Additionally, ProximaRX has confirmed that claim is still open. Services were rendered by the provider prior to the coverage expiration; therefore, it was still within the timeframe for covered services and the carrier should process payment for the billed services. This claim should be processed with the full amount billed as per Administrative Labor Code 134.503(c)."

Amount in Dispute: $428.69

Respondents' Position

"On this fourth dispute for the same Claimant…, the carrier also claims their holiday. This is the reason for the denial on the EOB of "coverage expired," since benefits are no longer covered. I have requested proof of the amount of the holiday and the date it went into effect and will supplement once received."

Response Submitted by: Downs & Stanford, P.C.

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).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. The Texas Labor Code §417.002 outlines the process for recovery in third-party settlements.

Denial Reasons

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

- @G (W3) – No additional reimbursement allowed after review of appeal/reconsideration.
- D2 (P12) – The charge for the over-the-counter medication exceeds the retail price.
- D3 (P12) – The charge for the prescription drug is greater than the maximum reimbursement for a generic drug.
- W3 @G – Service is included in the payment/allowance for another service/procedure that has been performed on the same day.
- P12 D3 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 @G – The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.
- TERM – Date of service after coverage expired.

Issues

1. Is there a third-party settlement in place for this claim?

Findings

1. This dispute pertains to the non-payment of prescription medications rendered on January 22, 2024, and billed under NDC No. 51991-0746-05, 50228-0180-10, and 49483-0699-01. The requestor is seeking a total reimbursement of $428.69.

   The insurance carrier in a response to Medical Fee Dispute Resolution, states, "On this fourth dispute for the same Claimant, U.G., the carrier also claims their holiday. This is the reason for the denial on the EOB of "coverage expired," since benefits are no longer covered. I have requested proof of the amount of the holiday and the date it went into effect and will supplement once received."

   Texas Labor Code §417.002(a-c), *Recovery in Third-Party Action*, states,

   > The net amount recovered by a claimant in a third-party action shall be used to reimburse the insurance carrier for benefits, including medical benefits, that have been paid for the compensable injury. (b) Any amount recovered that exceeds the amount of

the reimbursement required under Subsection (a) shall be treated as an advance against future benefits, including medical benefits, that the claimant is entitled to receive under this subtitle. (c) If the advance under Subsection (b) is adequate to cover all future benefits, the insurance carrier is not required to resume the payment of benefits. If the advance is insufficient, the insurance carrier shall resume the payment of benefits when the advance is exhausted.

The Division concluded that there was no evidence to contradict the carrier's assertion that a third-party settlement covers the disputed medications. Additionally, there was no evidence that the settlement's net value had been exhausted. As a result, the requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 TAC §133.307.

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.

The DWC finds the requestor has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		February 7, 2025
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, 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.