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
Texas Public School WC Project School Co

MFDR Tracking Number
M4-24-2878-01

Carrier's Austin Representative
Rep Box 18

DWC Date Received
August 24, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 10, 2024	NDC # 69584-0612-50	$78.18	$29.85

Requestor's Position

"ProximaRX has received several denials for the bill with date of service 04/10/2024. The carrier denied the original bill as well as the reconsideration based on (SERVICES NOT PROVIDED BY NETWORK/PRIMARY CARE PROVIDERS). ProximaRX did not receive any additional denial codes for the rejection of this bill from the carrier."
Amount in Dispute: $78.18

Respondent's Position

"CRF contends that the prescription for Methocarbamol was initiated by Anibal Rossel, who was a non-authorized doctor in this claim at the time this medication was dispensed. Consequently, no payment is due to ProximaRX."
Response Submitted by: Creative Risk Funding

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 §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. Texas Labor Code §408.021 establishes entitlement to medical benefits.

5. Texas Insurance Code §1305.101 defines the duties of networks to provide medical treatment.

Denial Reasons

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

- 242 – Services not provided by network/primary care providers.
- 243 - Services not authorized by network/primary care providers.

Issues

1. Is insurance carrier's denial reason(s) supported?

2. Is the requestor entitled to reimbursement?

Findings

1. The requestor is seeking reimbursement in the amount of $78.18 for medication(s) dispensed on April 10, 2024. The insurance carrier is denying reimbursement due to the denial reasons indicated above.

   Per Texas Insurance Code §1305.101(c), prescription medication may not, directly or through a contract, be delivered through a workers' compensation health care network.

   The division concludes that the disputed prescription medication dispensed by the provider is not subject to the provisions of a workers' compensation health care network.

Based on the documentation provided, DWC finds that the carrier failed to sufficiently support the denial for reimbursement. The requestor is therefore entitled to reimbursement for the medications in dispute.

2. 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 per unit) x (number of units) x 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
Methocarbamol	69584061250	G	0.68930	30	$29.85	$78.18	$29.85

The total reimbursement is $29.85. 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 $29.85 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement. It is ordered that respondent must remit to the requestor $29.85 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	September 26, 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 electronico CompConnection@tdi.texas.gov.