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
National Union Fire Ins Co of Pitts PA

MFDR Tracking Number
M4-24-2893-01

Carrier's Austin Representative
Rep Box 19

DWC Date Received
August 23, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 8, 2024	NDC # 72888-0012-00	$82.11	$34.76

Requestor's Position

"The original claim was denied for DUPLICATE BILL. An appeal was submitted to and received by the carrier on 07/29/2024. The appeal was denied by the carrier. The carrier cited new denial reasons under PARTIAL PAYMENT."
Amount in Dispute: $82.11

Respondent's Position

The Austin carrier representative for National Union Fire Ins Co of Pitts PA is Flahive, Ogden & Latson. Flahive, Ogden & Latson was notified of this medical fee dispute on September 5, 2024. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

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 (TAC) §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. 28 TAC §§134.530 and 134.540 sets out the closed formulary requirements, effective January 17, 2011, 35 TexReg 11344.

Denial Reasons

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

- 60 (B13) – The provider has billed for the exact services on a previous bill.

Issues

1. Is the insurance carrier's denial reason supported?

2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks payment in the amount of $82.11, for a prescription dispensed on April 8, 2024. The insurance carrier is denying/reducing reimbursement due to the denial reasons indicated above. DWC has not received a response from the carrier or its representative.

   The requestor indicates, "The original claim was denied for DUPLICATE BILL. An appeal was submitted to and received by the carrier on 07/29/2024. The appeal was denied by the carrier. The carrier cited new denial reasons under PARTIAL PAYMENT."

   Using the previously mentioned denial reduction codes, the insurance carrier audited and denied the disputed service. The idea that this bill was a duplicate bill is not supported by an examination of the medical records. Consequently, the insurance carrier's reason for denial is unsupported. The disputed service is therefore reviewed pursuant to the applicable rules and guidelines.

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
Cyclobenzaprine	72888001200	G	1.64	15	$34.76	$82.11	$34.76
				TOTAL	$34.76	$82.11	$34.76

The total reimbursement is $34.76. 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 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 the respondent must remit to the requestor $34.76 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	November 7, 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.