



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

ProximaRx

Respondent Name

Hartford Underwriters Insurance Co

MFDR Tracking Number

M4-24-2997-01

Carrier's Austin Representative

Rep Box 47

DWC Date Received

August 30, 2024

Summary of Findings

Date of Service	Disputed Service	Amount in Dispute	Amount Due
February 1, 2024	NDC # 29300-0124-10 Meloxicam 7.5 mg	\$247.62	\$0.00

Requestor's Position

"The carrier denied the reconsideration based on DUPLICATE CLAIM. The claim was not paid in full contrary to the carrier's reason for denial. It seems the carrier processed the claim but never issued a payment to our facility"

Amount in Dispute: \$247.62

Respondent's Position

"The original bill for dos 2/1/24 was received on 2/6/24 under control number 220689473 and paid per state fee schedule by Express Scripts."

Response Submitted by: The Hartford Financial Services Group, Inc.

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.

Denial Reasons

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

- 18 – Exact duplicate claim/service.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

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

Findings

1. The requestor is seeking reimbursement in the amount of \$247.62 for medication(s) dispensed on February 1, 2024. The insurance carrier is reducing reimbursement due to the denial reasons indicated above. The requestor indicates, "We are requesting that the carrier provide a proof of payment copy of the front and back of the check as well as the check description."

Based on the documentation provided by insurance carrier, DWC finds that the carrier failed to sufficiently support the reduction in 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
Meloxicam	29300012410	G	3.17	60	\$241.65	\$247.62	\$241.65

A review of the explanation of benefits provided by the requestor and the respondent support that a payment in the amount of \$241.65 was issued to the requestor. As a result, additional reimbursement is not 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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to \$0.00 additional reimbursement, for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

October 1, 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 electrónico CompConnection@tdi.texas.gov.