TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision
General Information

Requestor Name
Proximarx

Respondent Name
Starr Specialty Insurance Co.

MFDR Tracking Number
M4-25-0028-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 4, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 23, 2024	Ibuprofen NDC: 59651-0362-05	$78.05	$29.69
	Total	$78.05	$29.69

Requestor's Position

"The original bill was submitted to the carrier on 05/09/2024 VIA FAX CONFIRMATION... The reconsideration was submitted and received by the carrier on 07/05/2024 VIA FAX CONFIRMATION and then denied by the carrier... The carrier denied the reconsideration based on TIMELY FILING."

Amount in Dispute: $78.05

Respondent's Position

The Austin carrier representative for Starr Specialty Insurance Co. is Flahive Ogden & Latson. The representative was notified of this medical fee dispute on September 10, 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.

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).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.20 sets out requirements of medical bill submission by health care providers.
3. 28 TAC §134.503 sets out the fee guidelines for pharmaceutical services.

Denial Reasons

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

- B13: 60 - Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 60(B13) - The provider has billed for the exact services on a previous bill.
- P12 ZR - Workers' compensation jurisdictional fee schedule adjustment.
- P12 - The provider or a different provider has billed for the exact service on a previous bill where no allowance was originally recommended.
- XD(Pl2) - This bill was submitted after the billing timeliness guidelines provided.

Issues

1. Is the insurance carrier's reason(s) for denial supported?
2. What rules apply to the disputed service?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for prescription medication dispensed on February 23, 2024. The explanation of benefits (EOB) document dated June 24, 2024, cites the reason for reimbursement denial to be that the disputed services were previously paid.

   A review of the submitted documentation finds no evidence of previous payment for the medication dispensed on February 23, 2024.

   The explanation of benefits (EOB) document dated July 17, 2024, cites untimely submission of the medical bill as the reason for denial of reimbursement. 28 TAC §133.20, which sets out requirements of timely medical bill submission, states in pertinent part "(b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

A review of the submitted documentation finds that the EOB dated June 24, 2024, indicates the insurance carrier first received the medical bill for processing on May 9, 2024, less than 95 days from the disputed date of service of February 23, 2024. DWC finds that the requestor submitted the medical bill for the service in dispute in a timely manner in accordance with 28 TAC §133.20.

DWC finds that the insurance carrier's reasons for denial of reimbursement for the disputed medication dispensed on February 23, 2024, are not supported.

2. The service in dispute will be reviewed per applicable fee guideline. DWC Rule 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;

3. The requestor seeks reimbursement in the total amount of $78.05 for a prescription medication dispensed on February 23, 2024. Because the insurance carrier failed to support its denial reason(s) for payment of these medications, DWC will adjudicate for the maximum allowable reimbursement (MAR) for the disputed medications in accordance with 28 TAC §134.503(c).

Drug	Number Units Dispensed	NDC	Generic (G)/ Brand (B)	Price/Unit	AWP Formula	Billed Amount	Lesser of AWP and Billed Amount
Ibuprofen 800mg	30	59651-0362-05	G	$0.68500	$29.69	$78.05	$29.69

DWC finds that the requestor is entitled to reimbursement for the disputed drug dispensed on February 23, 2024, in the total amount of $29.69. Therefore, this amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies on the relevant evidence the requestor and respondent present at the time of adjudication. Although all the evidence in this dispute may not have been discussed, it was considered.

DWC finds the requestor has established that reimbursement is due in the total amount of $29.69.

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 Starr Specialty Insurance Co. must remit to Proximarx the amount of $29.69 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		December 13, 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 512-804-4812.