



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

ProximaRX

Respondent Name

American Casualty Co of Reading PA

MFDR Tracking Number

M4-25-0162-01

Carrier's Austin Representative

Box Number 57

DWC Date Received

September 19, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 18, 2024	43598-0977-10	\$77.81	\$0.00
April 18, 2024	58602-0773-21	\$64.72	\$0.00
Total		\$142.53	\$0.00

Requestor's Position

"I have attached the EOBs as well as the documentation to prove that ProximaRX has met the requirements to receive reimbursement."

Amount in Dispute: \$142.53

Respondent's Position

The Austin carrier representative for American Casualty Co of Reading PA is Continental Casualty Co. The representative was notified of this medical fee dispute on September 24, 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 §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. [28 Texas Administrative Code \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- A1 – Claim/Service denied. Disallowed Refill Too Soon.

Issues

1. Is the requestor's position supported?

Findings

1. The requestor is seeking reimbursement of the medications Diclofenac Gel1% and Pain Relief Tab 500mg. The insurance carrier denied the service stating the prescription was filled too soon. The requestor states in their position statement, "I have attached... the documentation to prove that ProximaRX has met the requirements to receive reimbursement."

DWC Rule 133.307 (c)(2)(N)(i)(iii) must send the request to the division in the form and manner prescribed by the division by any mail service, personal delivery, or electronic transmission as described in §102.5 of this title. The request must include

(N) a position statement of the disputed issue(s) that shall include:

- (iii) how the submitted documentation supports the requestor's position for each disputed fee issue;

A review of the documentation included a copy of a reconsideration that indicated the prior dispensed dates, however, insufficient information was found to support the prescribed dose, frequency and, prior adjudication of claims for the same medication. Based on this review, the DWC finds no payment is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that

additional reimbursement is due. As a result, the amount ordered is \$0.00.

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

Signature

Medical Fee Dispute Resolution Officer

January 23, 2025
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 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.