



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

ProximaRX

Respondent Name

Farmers Insurance Exchange

MFDR Tracking Number

M4-25-0396-01

Carrier's Austin Representative

Box Number 14

DWC Date Received

October 20, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 6, 2024	72888-0012-00	\$106.72	\$65.52

Requestor's Position

"The reconsideration was submitted and received by the carrier on **08/12/2024 VIA CERTIFIED MAIL**. ProximaRX did not receive any correspondence as per Rule 133.250(a) we submitted a Request for Reconsideration. I have attached proof of submission for the correspondence."

Amount in Dispute: \$106.72

Respondent's Position

"The bill was processed under bill id... and denied by the adjuster as Farmers has a dispute on file that services are not related to the compensable loss, therefore that is why this bill was not payable. No appeal was received for this date of service."

Response submitted by: Mitchell

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 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.503](#) sets out the fee guidelines for pharmacy services.

Denial Reasons

- 243 – Services not authorized by network/primary care provider.
- 91 – Dispensing fee adjustment.
- 95 – Plan procedures not followed.
- G01 – This item was priced as a generic prescribed drug.
- U00 – there was no UR procedure/treatment request received.
- XES – Services not authorized by network/primary care provider.

Issues

1. Is the respondent's position supported?
2. Is the insurance carrier's denial supported?
3. What rule is applicable to reimbursement?
4. Is the requestor entitled to reimbursement?

Findings

1. The respondent submitted a response to the request for MFDR that states, "...Farmers has a dispute on file that services are not related to compensable loss... No appeal was received for this date of service." DWC Rule 28 TAC §124.2(h) requires notification to the division and claimant of any dispute of disability or extent of injury using plain language notices with language and content prescribed by the division. Such notices "shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim."

Review of the submitted information finds no copies, as required by Rule §133.307(d)(2)(H), of any PLN-11 or PLN 1 notices issued in accordance with Rule §124.2. The insurance carrier's denial reason is therefore not supported. Furthermore, because the respondent failed to meet the requirements of Rule §133.307(d)(2)(H) regarding notice of issues of extent of injury, the

respondent has waived the right to raise such issues during dispute resolution. Consequently, the division concludes there are no outstanding issues of compensability, extent, or liability for the injury.

Additionally, the respondent indicates a request for reconsideration (appeal) was not received. The greater weight of evidence supports the requestor submitted a reconsideration request to the address listed on the explanation of benefits via United States Postal Service tracking # 9590 9402 4479 8248 0583 42. The disputed services are therefore reviewed pursuant to the applicable rules and guidelines.

2. The requestor seeks reimbursement of the medication (Cyclobenzaprine tab 5mg) for date of service June 6, 2024. The insurance carrier denied the claim for no network authorization.

Texas Insurance Code §1305.101 (c) states, "(c) Notwithstanding any other provision of this chapter, prescription medication or services, as defined by Section 401.011(19)(E), Labor Code, may not, directly or through a contract, be delivered through a workers' compensation health care network. Prescription medication and services shall be reimbursed as provided by Section 408.0281, Labor Code, other provisions of the Texas Workers' Compensation Act, and applicable rules of the commissioner of workers' compensation."

The disputed prescription medication dispensed by the provider is not subject to the provisions of a workers' compensation health care network. Because the insurance carrier failed to support its denial of payment, the requestor's disputed services are reviewed according to the applicable rules and guidelines.

Additionally, the explanation of benefits indicated a denial as "no UR procedure/treatment request received." DWC Rule 134.530 (b) (A) states in pertinent part, "Preauthorization is only required for drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A." Review of the applicable appendix A did not find the medication, cyclobenzaprine identified as a N drug. No authorization was required.

The insurance carrier's reasons for not processing the medication in dispute are not supported. The service in dispute will be reviewed per applicable fee guideline.

3. DWC Rule 28 Texas Administrative Code §134.503 (c)(1)(A)(B) states in pertinent part (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

(1) 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:

(A) Generic drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.09) + \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
Cyclobenzaprine	72888001200	G	1.64	30	\$65.52	\$106.72	\$65.52

4. The total reimbursement is \$65.52, 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 requester 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 Farmers Insurance Exchange must remit to ProximaRX \$65.52 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130

Authorized Signature

		January 16, 2025
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 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.