



Medical Fee Dispute Resolution Findings and Decision General Information

Requestor Name

ProximaRX

Respondent Name

Technology Insurance Company Inc.

MFDR Tracking Number

M4-25-0556-01

Carrier's Austin Representative

Box Number 17

DWC Date Received

November 4, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 21, 2024	Prescription medications	\$506.79	\$0.00
Total		\$506.79	\$0.00

Requestor's Position

"The explanation of benefits indicates that carrier paid \$0.00 and not the full amount of \$506.79. This claim should be processed with the full amount billed as per Administrative Labor Code 134.503(c)."

Amount in Dispute: \$506.79

Respondents' Position

"On this fifth dispute for the same Claimant..., the carrier also claims their holiday. This is the reason for the denial on the EOB of "coverage expired," since benefits are no longer covered. I have requested proof of the amount of the holiday and the date it went into effect and will supplement once received."

Response Submitted by: Downs & Stanford, P.C.

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).

Statutes and Rules

1. 28 Texas Administrative Code ([TAC](#)) [§133.305](#) sets out the procedures for resolving medical disputes.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
3. The Texas Labor Code [§417.002](#) outlines the process for recovery in third-party settlements.

Denial Reasons

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

- D2 (P12) – The charge for the over-the-counter medication exceeds the retail price.
- D3 (P12) – The charge for the prescription drug is greater than the maximum reimbursement for a generic drug.
- XD (P12) – This bill was submitted after the billing timelines guidelines provided.
- HE75 – Prior authorization required to process this bill.
- P12 D3 – Workers' compensation jurisdictional fee schedule adjustment.
- TERM – Date of service after coverage expired.

Issues

1. Does the claim have a third-party settlement?

Findings

1. This dispute pertains to the non-payment of prescription medications rendered on February 21, 2024 and billed under NDC No. 51991-0746-05, 65162-0102-50, 49483-0699-01 and 43598-0977-10. The requestor is seeking a total reimbursement of \$506.79.

The insurance carrier in a response to Medical Fee Dispute Resolution, states, "On this fifth dispute for the same Claimant, U.G., the carrier also claims their holiday. This is the reason for the denial on the EOB of "coverage expired," since benefits are no longer covered. I have requested proof of the amount of the holiday and the date it went into effect and will supplement once received."

Texas Labor Code §417.002(a-c), *Recovery in Third-Party Action*, states,

The net amount recovered by a claimant in a third-party action shall be used to reimburse the insurance carrier for benefits, including medical benefits, that have been paid for the compensable injury. (b) Any amount recovered that exceeds the amount of the reimbursement required under Subsection (a) shall be treated as an advance against future benefits, including medical benefits, that the claimant is entitled to receive under this subtitle. (c) If the advance under Subsection (b) is adequate to cover all future

benefits, the insurance carrier is not required to resume the payment of benefits. If the advance is insufficient, the insurance carrier shall resume the payment of benefits when the advance is exhausted.

The Division concluded that there was no evidence to contradict the carrier's assertion that a third-party settlement covers the disputed medications. Additionally, there was no evidence that the settlement's net value had been exhausted. As a result, the requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 TAC §133.307.

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.

The DWC finds the requestor has not established that reimbursement is due.

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

February 7, 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, 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.