TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
ProximaRx

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-25-0597-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
November 8, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 9, 2024	NDC # 59651-0362-05 Ibuprofen	$98.60	$55.38
February 9, 2024	NDC # 49483-0699-01 Acetaminophen	$72.18	$15.48
February 9, 2024	NDC # 29300-0419-01 Amitriptyline Hydrochloride	$67.04	$15.93
February 9, 2024	NDC # 72888-0014-00 Cyclobenzaprine Hydrochloride	$90.24	$44.93
	Total	$328.06	$131.72

Requestor's Position

"The Request for Reconsideration was submitted to and received by the carrier on 05/16/2024 via EMAIL CONFIRMATION. The Request for Reconsideration was submitted to and received by the carrier on 09/18/2024 via EMAIL CONFIRMATION for a third and final time."

Amount in Dispute: $328.06

Respondent's Position

"This is a denied claim. The provider filed a DWC 60 seeking medical fee dispute resolution for date of service of February 9, 2024. However, the provider is not entitled to medical fee dispute resolution unless and until the provider or the claimant prevail on the compensability issue."
Response Submitted by: Flahive, Ogden & Latson

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) §133.305 sets out the procedures for resolving medical disputes.
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 denied the payment for the disputed services with the following claim adjustment codes:

- HEA1 – Claim/service denied.
- CMR – Payment disallowed: Billing error: Line-item service previously processed electronically, and reimbursement/denial decision previously rendered.

Issues

1. Did the insurance carrier submit a copy of a PLN in support of the denial reason?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of Ibuprofen, Acetaminophen, Amitriptyline Hydrochloride and Cyclobenzaprine Hydrochloride dispensed on February 9, 2024. The insurance carrier denied the disputed prescriptions with denial code HEA1 – Claim/service denied. Respondent's response states "…the provider is not entitled to medical fee dispute resolution unless and until the provider or the claimant prevail on the compensability issue."

28 TAC §133.307(d)(2)(H), "Responses. Responses to a request for MFDR must be legible and submitted to the division and to the requestor in the form and manner prescribed by the division… (H) If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier must attach any related Plain Language Notice in accordance with §124.2 of this title (concerning Insurance Carrier Reporting and Notification Requirements)."

Review of the documentation submitted by the parties, finds that the carrier did not provide documentation to the Division to support that it filed a Plain Language Notice (PLN) regarding the disputed conditions as required by §133.307(d)(2)(H).

The respondent did not submit information to MFDR, sufficient to support that the PLN had ever been presented to the requestor or that the requestor had otherwise been informed of PLN prior to the date that the request for medical fee dispute resolution was filed with the DWC; therefore, the DWC finds that the compensability denial was not timely presented to the requestor. Because the service in dispute does not contain an unresolved compensability issue, this matter is eligible for adjudication of a medical fee under 28 TAC §133.307. For that reason, this matter is addressed pursuant to the applicable rules and guidelines.

2. The requestor billed for medications Ibuprofen, Acetaminophen, Amitriptyline Hydrochloride and Cyclobenzaprine Hydrochloride dispensed on February 9, 2024. Because the insurance carrier's denial reasons are not supported, the requester is entitled to reimbursement.

   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
Ibuprofen 800 MG	59651036205	G	0.68500	60	$55.38	$98.60	$55.38
Acetaminophen ER	49483069901	G	0.10200	90	$15.48	$72.18	$15.48
Amitriptyline HCl	29300041901	G	0.31800	30	$15.93	$67.04	$15.93
Cyclobenzaprine HCl	72888001400	G	1.09150	30	$44.93	$90.24	$44.93
				TOTAL	$131.72	$328.06	$131.72

The total reimbursement is $131.72. 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 is entitled to reimbursement in the amount of $131.72.

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 respondent must remit to the requestor $131.72 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 20, 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 electronico CompConnection@tdi.texas.gov.