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

General Information

Requester Name
ProximaRX

Respondent Name
Accident Fund Insurance Company of America

MFDR Tracking Number
M4-25-1691-01

Carrier's Austin Representative
Box Number 06

DWC Date Received
March 27, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 25, 2024	NDC No. 29300-0124-10 Meloxicam 7.5 mg	$152.56	$122.83
April 25, 2024	NDC No. 69584-0612-50 Methocarbamol 750 mg	$98.86	$55.70
	Total	$251.42	$178.53

Requester's Position

"….ProximaRX does not contract with any Pharmacy Benefit Managers (PBMs). ProximaRX sends claims to claimants' insurance carriers. As such, insurance carriers must make direct payment or, if they choose to make payment through a PBM, must ensure that the PBM is fulfilling payment obligations."

Amount in Dispute: $251.42

Respondent's Position

"This firm has been asked by Accident Fund Insurance Company of America to respond to the medical dispute referenced above. After review of the dispute, the Fund determined that payment was denied because the prescribing doctor was not authorized to treat the claimant because he was not a doctor within the Fund's certified workers' compensation network. The

Fund therefore stands on its denial of payment."

Response Submitted by: Stone Loughlin & Swanson, LLP

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).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.503 sets out the fee guidelines for pharmaceutical services.
3. 28 TAC §134.530 sets out the requirements of prior authorization.
4. TLC §408.021 TLC §408.021 establishes entitlement to medical benefits.
5. Chapter 1305 applicable to Health Care Certified Networks.

Denial Reasons

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

- 85 – Claim not processed.
- 75 – Prior authorization required.
- 65 – Patient is not covered.
- 70 – Drug not on formulary.

Issues

1. Are there any unresolved issue of regarding the compensability or liability of the disputed services?
2. Is the insurance carrier's denial supported by appropriate documentation?
3. Was prior authorization required for the disputed prescription medication?
4. Is the requester entitled to reimbursement?

Findings

1. The insurance carrier denied reimbursement for the prescription medication dispensed on April 25, 2024, citing denial reason code "65 – Patient is not covered." Upon review, the Division finds that the documentation submitted by the carrier does not sufficiently support this denial. Accordingly, the prescription medication in dispute will be reviewed under the applicable rules and guidelines.

2. The insurance carrier also asserted that payment was denied because the prescribing physician was not part of the Fund's certified workers' compensation healthcare network. Under the Texas Insurance Code §1305.101(c), prescription medications, as defined in Section 401.011(19)(E), Labor Code, are specifically excluded from delivery through a workers' compensation health care network, whether directly or via contract. Instead, reimbursement for such medications is governed by Section 408.0281 of the Labor Code, other relevant provisions of the Texas Workers' Compensation Act, and applicable rules established by the Commissioner of Workers' Compensation.

   Based on this, the Division finds that the prescription medication in question is not subject to network restrictions and should be reviewed under the appropriate reimbursement guidelines.

3. The requester seeks reimbursement for medication dispensed on April 25, 2024. According to 28 Texas Administrative Code (TAC) §134.530(b)(1)(A), preauthorization is required only for medications listed as "N" in the current edition of the ODG Workers' Compensation Drug Formulary (Appendix A). The medication dispensed on the above date is classified as a "Y" drug, indicating that preauthorization was not required. Therefore, the requester has met the criteria for reimbursement.

4. 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.

The calculation of the total allowable amount is as follows:

Drug	NDC	Generic(G) Brand(B)	Price/ Unit	Units Billed	AWP Formula	Billed Amount	Lesser of AWP and Billed
Meloxicam 7.5 mg	29300-0124-10	G	3.16870	30	$122.83	$152.56	$122.83
Methocarbamol 750 mg	69584-0612-50	G	0.68930	60	$55.70	$98.86	$55.70
				Total	**$178.53**	**$208.26**	**$178.53**

The Division of Workers' Compensation (DWC) has determined that the requester is entitled to reimbursement in the amount of $178.53. Consequently, this amount is recommended for payment.

Conclusion

The prescription medication dispensed on April 25, 2024, is not subject to network restrictions or preauthorization requirements. The insurance carrier's denial lacks sufficient justification. As such, the requester is entitled to reimbursement in accordance with the applicable Texas Workers' Compensation rules and guidelines.

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

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requester the amount of $178.53 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		July 18, 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 512-804-4812.