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

Requester Name
Proximarx

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-25-2177-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 9, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 11, 2024	00536-1172-01 Acetaminophen 500mg Tablet	$65.74	$8.04
September 11, 2024	16571-0107-10 Amitriptylin Tab 50mg	$89.17	$43.59
September 11, 2024	70710-1162-00 Meclizine Tab 25mg	$93.62	$49.15
	Total	$248.53	$100.78

Requester's Position

"The above claimant received medication, but the carrier has not acknowledged receipt of service. The original bill was submitted to the carrier on **09/13/2024 VIA FAX CONFIRMATION**..."

Amount in Dispute: $248.53

Respondent's Position

The Austin carrier representative for Zurich American Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on May 13, 2025.

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 (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. 28 TAC §134.503 effective October 23, 2011, 36 TexReg 6949 sets out the fee guidelines for pharmaceutical services before November 28, 2024.

Denial Reasons

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

- 29 – The time limit for filing has expired.
- 4271 – Per TX Labor Code Sec 408.027, providers must submit bills to payors within 95 days of the date of service.

Issues

1. Is the requester's position supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The requester states, "The original bill was submitted to the carrier on 09/13/2024…" The respondent did not submit a position statement or any other information to MFDR.

   The information submitted indicates a fax transmission of eight pages was sent on September 13, 2024 to fax number 563-855-7144. A second fax was sent to this same number on

December 23, 2024. The explanation of benefits submitted with the request for MFDR indicates that (Optum) acknowledged receipt of the second transmission on December 24, 2024. As the claim was faxed to the same number on two separate occasions and the carrier acknowledged receipt, the greater weight of evidence would support the claim was submitted originally on September 13, 2024 which was within 95 days of the date of service.

The service in dispute will be reviewed per applicable fee guidelines.

2. According to 28 TAC §134.503(c), reimbursement for prescription drugs must be calculated as the lesser of the amounts determined using formulas based on the Average Wholesale Price (AWP) in effect on the date the drug was dispensed, as published by a nationally recognized pharmaceutical pricing guide.

   For generic drugs, the formula is:
   (AWP per unit) × (number of units) × 1.25) + $4.00 dispensing fee = Reimbursement Amount

   The requester is entitled to reimbursement based on the applicable fee guidelines under 28 TAC §134.503.

   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
Acetaminophen	00536117201	G	0.0359	90	$8.04	$65.74	$8.04
Amitriptyline	16571010710	G	1.055	30	$43.59	$89.17	$43.59
Meclizine	70710116200	G	0.40	90	$49.15	$93.62	$49.15
					Total	$248.53	$100.78

3. The DWC finds that the requester is entitled to reimbursement in the amount of $100.78. Therefore, this amount is recommended.

Conclusion

Based on the evidence presented by both the requester and respondent at the time of adjudication, and upon review of applicable Texas Workers' Compensation rules and Medicare policies, the Division of Workers' Compensation finds:

- The billed services were submitted within 95 days.
- Therefore, the requester is entitled to reimbursement, and the amount due is $100.78.

Although not all submitted evidence is discussed in detail, it was fully considered in reaching this determination.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to $0.00 reimbursement for the disputed services. It is ordered that Zurich American Insurance

Co must remit to Proximarx $100.78 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

	Medical Fee Dispute Resolution Officer	July 30, 2025
Signature		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 three 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 tres o correo electronico CompConnection@tdi.texas.gov.