



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Proximarx

Respondent Name

AIU Insurance Co

MFDR Tracking Number

M4-25-2180-01

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
August 7, 2024	68462-0397-01 Omeprazole Cap 40mg	\$279.36	\$279.36

Requester's Position

"The above claimant received medications, and the carrier still has not acknowledged receipt of service. The original bill was submitted to the carrier on **08/09/2024 VIA FAX CONFIRMATION...**"

Amount in Dispute: \$279.36

Respondent's Position

The Austin carrier representative for AIU 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 §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 133.20](#) sets out the billing time line for medical bill submission.
3. [28 TAC 133.250](#) sets out the
4. [28 TAC §134.503](#) sets out the fee guidelines for pharmacy services.

Denial Reasons

- No explanation of benefits for the disputed medication was submitted by either party.

Issues

1. Did the requester support timely submission of the original bill?
2. Did the requester support a reconsideration of the denied charge was made timely?
3. What rule is applicable to reimbursement?
4. Is the requester entitled to reimbursement?

Findings

1. The requester provided evidence of a claim submission of four medications for date of service August 7, 2024 on August 9, 2024. A payment was made on three of the four medications on September 12, 2024. DWC Rule 133.20 (b) states in pertinent part, "...a health care provider must not submit a medical bill later than the 95th day after the date the services are provided." The requester supports the claim was submitted timely.
2. The requester submitted a request for reconsideration dated October 8, 2024 for payment of the medication. This reconsideration was sent to the insurance carrier with a USPS Tracking number of 9590 9402 4479 8248 0325 95. The date stamp from the USPS is Nov 19 (illegible). DWC Rule 133.250(b) states, "The health care provider shall submit the request for reconsideration no later than 10 months from the date of service. The greater weight of evidence supports the requester submitted a reconsideration request within 10 months of the date of service.

3. The requester seeks reimbursement of the medication Omeprazole Cap 40mg for date of service July 8, 2024. The respondent did not submit a position statement nor any documentation to support the non-payment of the disputed service. This line item will be reviewed per applicable fee guideline.

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
Omeprazole	68462039701	G	7.395	30	\$281.32	\$279.36	\$279.36

4. The total reimbursement is \$279.36, this amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester 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 additional reimbursement is due.

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 AIU Insurance must remit to Proximarx \$279.36 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

July 30, 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, 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 electrónico CompConnection@tdi.texas.gov.