TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
EZ Scripts LLC

Respondent Name
Lion Insurance Co

MFDR Tracking Number
M4-21-0079-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
September 16, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are not contracted with Optum, Tmesys, or Cypress Care but we were paid at the in-network rate. No contract was ever signed by EZ scripts."

Amount in Dispute: $182.81

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Austin carrier representative for Lion Insurance Co is JT Parker & Associates who was notified of this medical fee dispute on September 22, 2020. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information

As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 3, 2019 September 16, 2019 September 27, 2019 October 9, 2019	Prescription Medication	$182.81	$133.80

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the reimbursement of pharmacy services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - HE0L – Processed online through the Pharmacy Benefit Manager

Issue

1. Did the requestor waive the right to medical fee dispute resolution for date of service September 3, 2019?
2. Is the insurance carrier's reduction of payment supported?
3. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of pharmacy services rendered in September and October 2019. 28 TAC §133.307(c)(1) states in pertinent part unless a disputed service invoices issues of compensability extent of injury, liability, medical necessity or a refund the request for medical fee dispute resolution shall be filed no later than one year after the date(s) of service in dispute.

   The first disputed date of the service is September 3, 2019. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on September 16, 2020. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). DWC concludes that the requestor has failed to timely file this dispute with DWC's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for this date of service.

2. Regarding the remaining disputed dates of service. The insurance carrier reduced the payment amount based on a benefits payable through the pharmacy benefit manager. Insufficient evidence was found to support that a signed contract or written agreement exists between the requestor and the respondent. The maximum allowable reimbursement will be determined based on the fee guideline shown below.

3. 28 Texas Administrative Code §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;

Date of Service	Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
September 16, 2019	Diclofen Sodium Gel	65162083366	G	$0.548	100	$68.53	$68.53	$68.53
September 27, 2019	Diclofen Sodium Gel	65162083366	G	$0.548	100	$68.53	$73.00	$68.53
October 9, 2019	Diclofen Sodium Gel	65162083366	G	$0.548	100	$68.53	$73.00	$68.53

The total reimbursement is $205.59. The insurance carrier paid $71.79. A balance of $133.80 is due to the requestor.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established payment is due. As a result, the amount ordered is $133.80.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $133.80 plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 30, 2020 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 TAC §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall 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*** together with any other required information specified 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.