



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

Praetorian Insurance Co

MFDR Tracking Number

M4-21-0094-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

September 17, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was originally handled by Travelers... The claim was then switched over to Sedgwick after the correct employer was identified. Our bills were then submitted to Sedgwick in a timely manner."

Amount in Dispute: \$805.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Austin carrier representative for Praetorian Insurance Co is Flahive Ogden & Latson 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

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: November 25, 2019, December 17, 2019, February 7, 2020; Pharmacy Services; \$805.01; \$459.22

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 guidelines for pharmacy services.
3. 28 Texas Administrative Code §133.20 sets out the requirements for claim submission.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 27 – Expenses incurred after coverage terminated
 - XE – Bills are not payable if the number of days between the date of service/discharge and the submission date exceeds 95 days
 - B13 – The provider has billed for the exact services on a previous bill

Issues

1. Did the requestor submit the medical claim timely?
2. What rule applies to reimbursement of the disputed services?
3. Is the requestor due an additional payment?

Findings

1. The requestor is seeking reimbursement of pharmacy services rendered November 25, 2019, December 17, 2019 and February 7, 2019. The claims were denied by two carriers. The denials were as follows:

- Date of service November 25, 2019. Travelers shows claim received December 23, 2019 and processed February 13, 2020. This claim was denied for terminated coverage.

The same date of services was sent to Sedgwick on June 2, 2020. 28 TAC 133.20 (b) states in pertinent part the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill.

The requestor was informed of the wrong carrier on February 13, 2020. The claim was not submitted to the correct carrier until June 2020. This was beyond the ninety-five day filing requirement described above. The insurance carrier's denial for this date of service is upheld.

- Date of service December 17, 2019. Travelers denied on February 4, 2020 as coverage terminated. Sedgwick received the claim July 28, 2020 and denied the claim on August 3, 2020 as past timely filing. The requestor was informed of the wrong carrier on February 4, 2020. The claim was not submitted to the correct carrier until July 2020. This was beyond the ninety-five day filing requirement. The insurance carrier's denial for this date of service is supported.
- Date of service February 7, 2020. The Division of Workers' Compensation Commissioner issued Bulletin # B-0010-20 which states in pertinent part that failure to submit a timely medical bill will be deemed an exception due to a catastrophic event under Labor Code Section 408.0272(b)(2). The date this bulletin was issued was March 25, 2020. Ninety-five days prior to the issuance date was December 20, 2019. Dates of service December 20, 2019 and after will have the filing deadline tolled. The disputed date of service is February 7, 2020, the insurance carrier's denial is not supported based on DWC Commissioner's Bulletin # B-0010-20. This date of service will be reviewed per applicable fee guideline.

2. 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 \text{ per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;
 - Brand name drugs: $((AWP \text{ 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 (dispensing fee not submitted)	Billed Amt	Lesser of AWP and Billed
Diclofenac Sodium Transdermal Gel	65162083366	G	0.548	100	\$68.53	\$72.53	\$68.53
Celecoxib	33342015715	G	7.57	30	\$283.88	\$287.88	\$283.88
Sertraline	65862001205	G	2.84	30	\$106.81	\$110.81	\$106.81
							\$459.22

3. The total reimbursement is \$459.22. This amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$459.22.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$459.22, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 3, 2020 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §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 MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **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.