TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
EZ SCRIPTS LLC

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-21-0843-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
January 28, 2021

REQUESTOR'S POSITION SUMMARY

"Enclosed are the outstanding pharmacy bills from Mail My Meds LLC d/b/a Public Safety, Rx, which were submitted to Liberty Mutual Insurance in a timely manner after each prescription was filled. Liberty Mutual Insurance has refused to pay the enclosed invoices at the fee schedule."

Amount in Dispute: $199.64

RESPONDENT'S POSITION SUMMARY

"We base our payments on the Texas Fee Guidelines and the Texas Department of Insurance Division of Workers' Compensation Acts and Rules."

Response Submitted by: Helmsman Management Services LLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 14, 2020	Prescription Medication	$199.64	$0.00

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 (DWC).

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 fee guidelines for pharmaceutical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 4282 – Drugs identified with a status of "Y" in the current edition of the "Official Disability Guidelines Treatment in Workers' Comp" (ODG/Appendix A, "ODG Workers' Compensation Drug Formulary" Identify a drug that can be dispensed without preauthorization. The allowance has been determined in according to the pharmacy fee guidelines.

Issues

Is EZ Scripts, LLC entitled to additional reimbursement for the drug in question?

Findings

EZ Scripts, LLC is seeking additional reimbursement for Naproxen SOD 550 mg dispensed on April 14, 2020. Per explanation of benefits dated June 9, 2020, the insurance carrier paid $71.50 for this drug.

The insurance carrier is required to pay the lesser of the DWC's pharmacy formulary 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, or the billed amount.[1]

EZ Scripts, LLC is requesting an additional reimbursement of $199.64 for the disputed drug. EZ Scripts, LLC has the burden to support its request for this amount. It did not demonstrate how it arrived at the requested amount or whether that amount is consistent with the methodology under 28 TAC §134.503 (c) in its position statement. The insurance carrier provided evidence that supports that it based its reimbursement on Redbook.

After notification by the DWC's medical fee dispute resolution program of the insurance carrier's response, EZ Scripts, LLC did not take the opportunity to refute the insurance carrier's payment calculation. The DWC finds that no additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		March 18, 2021
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 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 the DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the 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 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

[1] 28 TAC §134.503 (c)