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
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-21-1004-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
February 24, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Gallagher Bassett has effectively refused to pay the enclosed invoices whether partially or in full."

Amount in Dispute: $450.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Billings not received within 95 day from DOS."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 27, 2020	Oral medication	$90.00	$343.56
June 4, 2020		$90.60	
July 7, 2020		$90.60	
August 3, 2020		$90.00	
October 21, 2020		$89.40	

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 fee guidelines for pharmaceutical services.
3. The following denial was made by the insurance carrier.
   - 29 – The time limit for filing has expired

Issues

1. Is the insurance carrier's denial supported?
2. What rule(s) apply to the fee guideline for the disputed services?

Findings

1. The requestor is seeking reimbursement for oral medication dispensed From April to October 2020. The insurance company denied the claims as not filed within ninety-five days.

   DWC Commissioners' Bulletin # B-0010-20 issued March 25, 2020 details the medical billing deadlines have been tolled under provisions of Labor Code Section 408.0272(b)(2) due to a catastrophic event. The insurance carriers' denial is not supported for dates of service June 4, July 7, August 3 and October 21, 2020.

   28 TAC §133.307 (2) (J) states in pertinent part the requestor must send the request to the division in the form and manner prescribed by the division by any mail service, personal delivery, or electronic transmission as described in §102.5 of this title and include a copy of all medical bills related to the dispute as originally submitted to the insurance carrier.

   The requestor did not submit a copy of the original medical bill for date of service April 27, 2020. The date of service April 27, 2020 will not be considered in this review.

2. 28 TAC §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	Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
June 4, 2020	Naproxen	65162019050	G	1.146	60	$86.01	$90.01	$86.01
July 7, 2020	Naproxen	65162019050	G	1.146	60	$86.01	$90.01	$86.01
August 3, 2020	Naproxen	65162019050	G	1.146	60	$86.01	$90.01	$86.01
October 21, 2020	Naproxen	50228043605	G	1.14	60	$85.53	$89.53	$85.53
								$343.56

The total reimbursement is $343.56. 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 $343.56.

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 $343.56, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		March 11, 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 division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division 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.