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
Zurich American Insurance Co

MFDR Tracking Number
M4-21-1005-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 24, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The medications Meloxicam, Cyclobenzaprine, Ibuprofen, and Naproxen were all approved drugs on the Texas Drub Formulary and did not require preauthorization for any of these medications."

Amount in Dispute: $539.74

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: March 15, 2021 "The request for dispute resolution regarding DOS 02/07/2020 should be dismissed as untimely. The DWC-60 was receive by the Division on 02/24/21."

April 5, 2021 "The Carrier has re-audited the bill for DOS 5/11/20, and has paid the bill per fee guideline as reflected in the attached EOB."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 7, 2020 May 11, 2020	Oral medication	$539.74	$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.

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:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - TERM – Date of service after Coverage expired

Issues

1. Did the requestor waive the right the medical fee dispute resolution?
2. What rule(s) apply to disputed services?

Findings

1. The requestor is seeking reimbursement of oral medication dispensed February 7, 2020. 28 TAC 133.307(c)(1) states in pertinent part a request for medical fee dispute resolution that does not involve compensability, extent of injury, liability, medical necessity or a refund shall be filed no later than one year after the date(s) of service.

   The date of the service in dispute is February 7, 2020. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on February 24, 2021.

   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 above. 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.

2. The requestor submitted date of service May 11, 2020 for medical fee dispute. The insurance company provided evidence of $109.30 paid on March 29, 2021. The service in dispute will be reviewed per applicable fee guideline.

   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;

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Ibuprofen	67877032105	G	0.80	60	$60.37	$64.37	$64.37
Cyclobenzaprine	43547040011	G	1.09	30	$40.93	$44.93	$44.93

The total reimbursement is $109.30. The insurance carrier paid $109.30. No additional payment 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 not established that additional reimbursement is due. As a result, no payment is due.

ORDER

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

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 28, 2021 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.