TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

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
M4-24-0436-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
October 24, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 2, 2023	70954-0020-10 Prazosin HCL 2mg	$53.40	$0.00
	Total	$53.40	$0.00

Requestor's Position

"The dispensed medication is directly related to the patient's injury and was prescribed as treatment of the patient's worker's compensation claim which has been verified as open and compensable for this treating provider. Documentation has been attached to each bill in support of necessary reimbursement."

Supplemental response December 8, 2023

"We don't have record of this payment. Can they provide further information?

Supplemental response January 12, 2024

"Payment was received and will be adjusted on our end, there still remains the issue of the underpayment for 31722000290 Venlafaxine."

Amount in Dispute: $53.40

Respondent's Position

"The bill related to the above captioned MDR has been paid. A copy of the payment issued, print out of the confirmation screen showing the check has been paid by the bank is attached and the original EOR issued are attached."

Supplemental response December 15, 2023

"A copy of the endorsed check is attached."

Supplemental response December 19, 2023

"My apologies, I have reviewed this again and apparently the wrong check was sent to me… I have requested a copy of the correct endorsed check and I will forward it to you as soon as it is received."

Supplemental response January 2, 2024

"A copy of the endorsed check is attached. I have also included another copy of the EOR that shows the allowance made for the medication in question."

Response submitted by: ESIS

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 1 – The billed amount for drug or supply exceeds Medispan allowance.
- 2 – P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Has the insurance carrier supported payment for the disputed charge listed on the DWC60?

Findings

1. The insurance carrier submitted evidence of a payment made on February 6, 2023, in the amount of $53.58 under control number 510772997 for the date of service on February 2, 2023, RX 70954-0020-10 Prazosin HCL. This payment is more than the amount requested at the time of MFDR. No additional payment is recommended.

   Additionally, the requestor indicated an issue still existed for RX 31722-0002-90 Venlafaxine. The submitted DWC60 did not include a request for this medication. This medication will not be considered.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

		January 26, 2024
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must 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*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.