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**
Old Republic Insurance Company

**MFDR Tracking Number**
M4-24-1032-01

**Carrier's Austin Representative**
Box Number 44

**DWC Date Received**
January 15, 2024

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| February 3, 2023, and April 3, 2023 | Prescribed Medications | $409.14 | $409.14 |
| | **Total** | $409.14 | $409.14 |

## Requestor's Position

"Optum bill review denied the Tizanidine HCL 4 MG based on 'entitlement to benefits.' Many attempts were made to get in touch with the adjuster to gain more information on this denial with no response. The same medication was paid for dates of service 12/03/22, 05/12/23, 06/09/23, and 07/21/23. Optum bill review denied the Celecoxib 100 MG filled on 04/03/23 as previously paid. We did not receive payment for this date of service. EZ Scripts is asking that the Division of Workers' Compensation order Sedgwick Claims Management Services, Inc. to pay our outstanding balance."
**Amount in Dispute:** $409.14

## Respondent's Position

"The Austin carrier representative for Old Republic Insurance Company is White Espey PLLC. White Espey PLLC was notified of this medical fee dispute on January 23, 2024. 28 TAC §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 28 TAC §133.307(d)(1).

# 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).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.503 sets out the fee guidelines for pharmaceutical services.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- VPEB – Denied – Based on entitlement of benefits.
- N3 (B20) – A reduction was made because a different provider has billed for the exact services on a previous bill.
- ZR (P12) – The provider or a different provider has billed for the exact services on a previous bill where no allowance was originally recommended.
- B20: N3 – Procedure/service was partially or fully furnished by another provider.
- P12: ZR – Workers' compensation jurisdictional fee schedule adjustment.
- B13: 60 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 60 (B13) – The provider has billed for the exact services on a previous bill.

Issues

1. Is the insurance carrier's denial reason supported?
2. What rules apply to disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor is seeking reimbursement for prescribed medication dispensed on February 3, 2023, and April 3, 2023. The insurance carrier has not responded to the DWC060 request. As a result, a decision is issued based on the documentation contained in the dispute at the time of the review.

   The insurance carrier denied the disputed services with the denial reduction codes indicated above.

A review of the documentation does not find that the insurance carrier provided copies of a PLN in support of the denial "Based on entitlement of benefits."

A review of the documentation does not support that the disputed services were rendered or furnished by another provider.

A review of the documentation does not support that a previous payment was issued for the disputed service.

A review of the documentation does not support that the requestor billed for the exact services on a previous bill.

DWC finds that insufficient evidence was provided to support the insurance carrier's denial reasons. The requestor is therefore entitled to reimbursement for the medications in dispute.

2. Rule 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.

The calculations of the total allowable amount for each medication are as follows:

| Drug | NDC | Generic(G) /Brand(B) | Price/ Unit | Units Billed | AWP Formula | Billed Amount | Lesser of AWP and Billed |
|---|---|---|---|---|---|---|---|
| Tizanidine HCL 4mg | 55111-0180-10 | G | $1.46507 | 30 | $58.94 | $58.94 | $58.94 |
| Celecoxib 100mg | 33342-0156-15 | G | $4.61600 | 60 | $350.20 | $350.20 | $350.20 |
| | | | | | **Total** | $409.14 | $409.14 |

3. The DWC finds that the requestor is entitled to reimbursement in the amount of $409.14. Therefore, this amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies on the relevant evidence the requester and respondent present at the time of adjudication. Although all the evidence in this dispute may not have been discussed, it was considered.

The DWC finds the requester has established that reimbursement is due. As a result, the amount ordered is $409.14.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requester the amount of $409.14 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

**Authorized Signature**

| | | |
|---|---|---|
| | | May 13, 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 512-804-4812.