TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
EZ Scripts LLC

Respondent Name
Harris County

MFDR Tracking Number
M4-24-1582-01

Carrier's Austin Representative
Box Number 21

DWC Date Received
March 15, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 24, 2023	58468-0090-01	$1795.46	$0.00
September 27, 2023	00406-0484-01	$12.63	$0.00
	Total	$1,755.80	$0.00

Requestor's Position

"EZ Scripts seeks an additional payment of $12.63 for the Acetaminophen-Codeine 300-30MG. The carrier only issued payment in the amount of $27.03. This is a CIII medication. DWC Rule 28 Texas Administrative Code §134.503(c)(1)(A) states... ...Synvisc 8MG/ML was filled on 08/24/2023 and sent to the doctor's office to administer. EZ Scripts submitted preauthorization which was approved by Injury Management Organization. IMO approved the request with ID 264104 and authorization number 169291."

Amount in Dispute: $1,755.80

Respondent's Position

"Based on a review of the claim history and submitted documentation for date of service 9/27/23 an additional recommendation is being made in the amount of $13.00 including interest. In regard to date of service 08/24/23 for the Synvisc 8mg/ml inj meds our review found the provider distributed the medication prior to the approval of the authorization determination. The request

for prior authorization was made on 08/24/23 by EZ Scripts and distributed on the same day, per the Preauthorization Determination Letter attached; the decision of approval was not made until 8/29/23 resulting in the early distribution of the medication. Due to this finding the denial is appropriate."

Response submitted by: Injury Management Organization

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.
2. 28 TAC §134.530 sets out the requirements of approval of drugs excluded from the closed formulary.
3. 28 TAC §503 sets out the fee guidelines for pharmacy services.

Denial Reasons

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

- 16 – Claim/service lacks information or has submission/billing error(s).
- 219 – Based on extent of injury.
- 51 – These are non-covered services because this is a pre-existing condition.
- P12 – Workers compensation jurisdictional fee schedule adjustment.
- 18 – Exact duplicate claim/service.
- 197 – Precertification/authorization/notification/pre-treatment absent.
- 129 – Prior processing information appears incorrect.

Issues

1. Did the respondent support payment of Acetaminophen-Codeine Phosphate?
2. Did the requestor support that Synvisc was prior authorized on date of service?

Findings

1. The requestor is seeking additional reimbursement of NDC 00406-0484-01, Acetaminophen-Codeine. The requestor billed $39.66. Review of the submitted documentation found the following payments were made.

    - October 19, 2023 via check 179310 a payment of $27.03.
    - April 5, 2024 via control number 6066563 in the amount of $12.63 allowed amount and $0.37 interest.
    - The total paid (not including interest) equals $39.66.

    DWC Rule 28 TAC §134.503(c)(1)(2)(A) states in pertinent parts, The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

    (1) 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:

    (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:

    (A) health care provider;

    The insurance carrier supported reimbursement of $39.66 which was the amount billed by the health care provider. No additional payment recommended.

2. The requestor is seeking reimbursement of Synvisc 8MG/ML for date of service August 24, 2023. Review of the submitted documentation found the requestor sought advance approval of the medication. The "Preauthorization Determination Letter" dated August, 29, 2023 indicates authorization was given for dates of service August 29, 2023 to December 15, 2023. The date of service for this dispute is August 24, 2023. This date is prior to the prior authorization. The denial for lack of prior authorization is supported. The denial for extent of injury was not maintained. No payment is recommended.

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that reimbursement is due.

Order

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

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 11, 2024 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.