



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

EZ Scripts LLC

Respondent Name

Hanover American Ins Co

MFDR Tracking Number

M4-24-1623-01

Carrier's Austin Representative

Rep Box 47

DWC Date Received

March 28, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 1, 2023	NDC # 21922-0009-09 Diclofenac Sodium 1% gel	\$365.00	\$365.00
Total		\$365.00	\$365.00

Requestor's Position

"Enclosed is the outstanding pharmacy bill from EZ Scripts, which was submitted to Hanover Insurance Company in a timely manner after the prescription was filled. The carrier is refusing to issue payment. Multiple attempts have been made to contact the adjuster and find out why the bill was denied."

Amount in Dispute: \$365.00

Respondent's Position

"The reason stated for the dispute is the nonpayment of Date of Service 05/01/2023 for Diclofenac. After careful review of the submitted documentation from the provider it was determined that the date of service was denied as the claimant had reached Maximum Medical Improvement and discharged from care on 9/9/2022."

Response Submitted by: The Hanover Insurance Group

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 §133.305](#) sets out the general procedures for medical dispute resolution.
2. [Texas Labor Code §408.21](#) sets out workers' compensation entitlement to benefits guidelines.
3. [Texas Labor Code §415.002](#) details administrative violation pertaining to statement denying future medical benefits.
4. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
5. [28 TAC §134.503](#) sets out the fee guidelines for pharmacy.

Denial Reasons

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

- N3 (B20) – A reduction was made because a different provider has billed for the exact services on a previous bill.
- HMMI – Patient has been released to Maximum Medical Improvement.
- B20: N3 Procedure/service was partially or fully furnished by another provider.
- TERM – Date of service after coverage expired.

Issues

1. Is the insurance carrier's denial supported?
2. What rule is applicable to reimbursement?
3. Is requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of the medication Diclofenac Sodium 1% gel dispensed May 1, 2023. The insurance carrier denied stating coverage had expired, duplicate and patient released to MMI.

Sec. 408.021. ENTITLEMENT TO MEDICAL BENEFITS. (a) An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury

as and when needed. The employee is specifically entitled to health care that:

- (1) cures or relieves the effects naturally resulting from the compensable injury.
- (2) promotes recovery; or
- (3) enhances the ability of the employee to return to or retain employment.

(b) Medical benefits are payable from the date of the compensable injury.

(c) Except in an emergency, all health care must be approved or recommended by the employee's treating doctor.

(d) An insurance carrier's liability for medical benefits may not be limited or terminated by agreement or settlement

Sec. 415.002. ADMINISTRATIVE VIOLATION BY INSURANCE CARRIER... (a) An insurance carrier or its representative commits an administrative violation if that person... (21) makes a statement denying all future medical care for a compensable injury..."

The DWC finds that the insurance carrier's denial reason is not supported. The disputed service is therefore reviewed pursuant to the applicable rules and guidelines.

2. DWC Rule 28 Texas Administrative Code §134.503 (c)(1)(A)(B) states in pertinent part (c) 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:

(A) Generic drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.09) + \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
Diclofenac Sodium	21922000909	G	0.58	500	\$368.69	\$365.00	\$365.00
						\$365.00	\$365.00

3. The total reimbursement is \$365.00. This amount is recommended.

Conclusion

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 established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Hanover American Ins Co must remit to EZ Scripts LLC \$365.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

June 17, 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, 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 electrónico CompConnection@tdi.texas.gov.