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
Ace American Insurance Co

MFDR Tracking Number
M4-24-2629-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
August 1, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 20, 2024	55111-0683-05 Ibuprofen 600mg	$15.25	$0.00
March 7, 2024	55111-0683-05 Ibuprofen 600mg	$15.25	$0.00
April 1, 2024	55111-0683-05 Ibuprofen 600mg	$15.25	$0.00
	Total	$45.75	$0.00

Requestor's Position

"EZ Scripts seeks an additional payment for the date of service."

Amount in Dispute: $45.75

Respondent's Position

"It has been determined that ESIS Med Bill Impact will stand on the original recommendation of $6.75. Brand name drug was prescribed and was replaced by the Generic Equivalent per the fee schedule."

Response submitted by: ESIS Disputes Team

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 §134.430 sets out the requirements of reimbursement of implants.

Denial Reasons

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

- (387) – Brand name drug replaced with generic equivalent based on Fee Schedule guidelines.
- 18 – Duplicate claim/service
- P12 – Workers compensation jurisdictional fee schedule adjustment.

Issues

1. Is EZ Scripts, LLC entitled to additional reimbursement for the drug in question?

Findings

1. EZ Scripts, LLC is seeking additional reimbursement for Ibuprofen 600 mg dispensed on February 20, 2024, March 7, 2024 and April 1, 2024. Per submitted explanation of benefits the insurance carrier paid $6.75 for each prescription.

   The insurance carrier is required to pay the lesser of the DWC's pharmacy formulary 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, or the billed amount.

   EZ Scripts, LLC is requesting an additional reimbursement of $15.25 for each prescription for a total of $45.75 additional reimbursement for the disputed drug.

   EZ Scripts, LLC has the burden to support its request for this amount. Review of the submitted documents found a document from "RC Reimbursement Codes from 2023. This document does not demonstrate how it is consistent with the methodology under 28 TAC §134.503 (c).

EZ Scripts, LLC did not take the opportunity to refute the insurance carrier's payment calculation. The DWC finds that no additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

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	September 5, 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.