



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

EZ Scripts LLC

Respondent Name

Ace American Insurance Co

MFDR Tracking Number

M4-24-3003-01

Carrier's Austin Representative

Rep Box 15

DWC Date Received

August 30, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 30, 2024	NDC # 5511-0683-05	\$15.25	\$12.97
May 23, 2024	NDC # 5511-0683-05	\$15.25	\$12.97
Total		\$30.50	\$25.94

Requestor's Position

"Enclosed are the outstanding pharmacy bills from EZ Scripts, which were submitted to ESIS, Inc. in a timely manner after each prescription was filled. Ibuprofen 600 MG was paid incorrectly by the carrier."

Amount in Dispute: \$30.50

Respondent's Position

"ESIS Med Bill Impact's Bill Review Department reviewed the above-mentioned date of service and found that the provider was not due additional money. It has been determined that ESIS Med Bill Impact will stand on the original recommendation of \$6.75. Bills processed per fee schedule. Brand name drug replaced with Generic equivalent."

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 §133.305](#) sets out the general procedures for medical dispute resolution.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
3. [28 TAC §134.503](#) sets out the fee guidelines for pharmacy.

Denial Reasons

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

- 1 – Brand name drug replaced with generic equivalent based on fee schedule guidelines.
- 2 P12 - Workers' compensation jurisdictional fee schedule adjustment.
- 6 - Previous recommended history on DCN(s): 511703462=\$6.75 (387, ANSIP12)

Issues

1. Is insurance carrier's denial reason(s) supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement in the amount of \$30.50 for medication(s) dispensed on April 30, 2024, and May 23, 2024. The insurance carrier is reducing reimbursement due to the denial reasons indicated above.

Based on the documentation provided, DWC finds that the carrier failed to sufficiently support the denial for reimbursement. The requestor is therefore entitled to reimbursement for the medications in dispute.

2. 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;
- Brand name drugs: ((AWP per unit) x (number of units) x 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 Amt
Ibuprofen	55111-0683-05	B	0.24	60	\$19.72	\$22.00	\$19.72
Ibuprofen	55111-0683-05	B	0.24	60	\$19.72	\$22.00	\$19.72
TOTAL					\$39.44	\$44.00	\$39.44

The total reimbursement is \$39.44; the carrier paid \$6.75 on April 30, 2024, and May 23, 2024, for a total of \$13.50; therefore, the requestor is entitled to an additional payment of \$25.94.

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 requestor has established that additional reimbursement of \$25.94 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to an additional payment of \$25.94 reimbursement. It is ordered that respondent must remit to the requestor \$25.94 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

September 23, 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.