



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

EZ Scripts LLC

Respondent Name

Hartford Casualty Insurance Co

MFDR Tracking Number

M4-25-0527-01

Carrier's Austin Representative

Box Number 47

DWC Date Received

October 30, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Findings
December 8, 2023	50228-0180-10	\$203.80	\$203.80
December 8, 2023	42858-002-01	\$91.50	\$24.75
January 8, 2024	00406-0552-01	\$117.61	\$0.00
	Total	\$412.91	\$228.55

Requestor's Position

"Gabapentin 300 mg and Oxycodone HCL 10 mg were denied with the code "Claim/Service denied." The only form of this medication found not medically necessary was Oxycodone ER 9 mg. The medical records support the use of these medications. Oxycodone HCL 5 mg filled on 01/08/2024 was denied with the code "HEMD: These are non-covered services because this is not deemed a 'medical necessity' by the payer" The only form of this medication found not medically necessary was Oxycodone ER 9 MG. The medical records support these medications."

Amount in Dispute: \$412.91

Respondent's Position

"As reflected in the EOBs, Hartford Casualty Insurance Company properly denied reimbursement to EZ Scripts in accordance with the Texas Workers' Compensation Act and Division Rules based on a review by Edward Requenez, M.D."

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 §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.503](#) sets out the fee guidelines for pharmacy services.
3. [28 TAC §133.240](#) sets out requirements of utilization review determination.
4. [Texas Administrative Code §19.2009](#) sets out the requirements of utilization review determination notices.
5. [TAC §19.2010](#) sets out the requirements prior to issuing adverse determinations.
6. [28 TAC 134.500](#) defines prescription.

Denial Reasons

- HE83 – Duplicate Paid/Captured Claim
- HEA1 – Claim/Service denied.
- HEMD – These are non-covered service because this is not deemed a 'medical necessity' by the payer.
- N3 – (B20) – A reduction was made because a different provider has billed for the exact services on a previous bill.
- ZR, E1, E3, – P12 – Workers' compensation jurisdictional fee schedule adjustment
- E1(P12) – The provider does not appear to have a valid Drug Enforcement Agency (DEA) ID on file. As the service rendered is a drug item classified by the DEA as a federally controlled substance, it is recommended the provider submit an updated DEA ID in order to remain compliant.
- E3(P12) – The provider dispensed a drug item classified by the Drug Enforcement Agency (DEA) as a federally controlled substance with a DEA Class of CI, CII or CV. The Controlled Substances Act monitors these classes of drugs due to the high abuse potential.

- 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 service on a previous bill where no allowance was originally recommended.

Issues

1. Is the insurance carrier's denial supported for dates of service December 8, 2023?
2. Is the insurance carrier's denial supported for date of service January 8, 2024?
3. What rule(s) apply to disputed services?

Findings

1. The requestor is seeking reimbursement of the following.

- 50228-0180-10, (Gabapentin) Date of service, December 8, 2023
- 42858-0002-01, (Oxycodone Hydrochloride), Date of service, December 8, 2023

Date of service, December 8, 2023 for the Gabapentin was denied as a duplicate claim. Insufficient evidence was found to support a previous payment for the disputed medication and date of service. The medication Gabapentin for the disputed date of service December 8, 2023, will be reviewed per applicable DWC Rule.

The insurance carrier denied the medication Oxycodone Hydrochloride 10 mg for date of service December 8, 2023 as "Claim denied." No further explanation was provided in the respondent's position statement or EOBS.

DWC Rule 28 Texas Administrative Code §133.240 (q) states, in relevant part, "When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title ... Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of TAC §19.2010 of this title ..., including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor ..."

Submitted documentation does not support that the insurance carrier followed the appropriate procedures for a retrospective review denial of the disputed services outlined in TAC§19.2003 (b)(31) or §133.240 (q). Therefore, the insurance carrier did not appropriately raise medical necessity for this dispute and this denial reason will not be considered in this review

Review of the submitted documents found Sedgwick performed a medical necessity review of the medication Oxycodone ER 9mg. This medication is not in dispute, the denial for Oxycodone Hydrochloride 10mg for date of service December 8, 2023 is not supported. The claim will be reviewed per applicable fee guideline.

2. The requestor is seeking reimbursement of the following.

- 00406-0552-01, Oxycodone Hydrochloride, Date of service, January 8, 2024

The insurance carrier denied the medication stating the DEA number on file was not valid. DWC Rule 28 TAC 134.500 (12)(A) that states in pertinent part the prescription must be legally prescribed under federal or state law or Texas Administrative Code, Chapter 315 which defines the requirements for controlled substance prescribing.

Review of the submitted documents found insufficient evidence was submitted by the requestor to refute this denial. The insurance carrier’s denial is supported.

3. 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
Gabapentin	50228018010	G	1.332	120	\$203.80	\$203.80	\$203.80
Oxycodone	42858000201	G	0.148	112	\$24.75	\$91.50	\$24.75

The total reimbursement is \$228.55. 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 requestor has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that Hartford Casualty Insurance Co must remit to EZ Scripts \$228.55 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

November 27, 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 electrónico CompConnection@tdi.texas.gov.