TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION
FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Injured Workers' Pharmacy

Respondent Name
Texas Mutual Insurance Co (TMIC)

MFDR Tracking Number
M4-18-2629-01

Carrier's Austin Representative Box
Number 54

Fee Dispute Request Received
March 21, 2018

Response Submitted by:
TMIC

REQUESTOR POSITION SUMMARY

"Texas Mutual Insurance Co has sent payment to Cypress Care, despite that the DWC066 form indicates Injured Workers' Pharmacy, LLC as both the filing pharmacy and the payee."

RESPONDENT POSITION SUMMARY

"This is a dispute between the requestor and Cypress Care, dba Optum, Texas Mutual's pharmacy benefit manager."

SUMMARY OF REQUEST AND DIVISION ORDER

Disputed Dates of Service	Disputed Service	Disputed Amount	Division Order
August 30, 2017	Omeprazole Cap 40 MG	$558.66	$558.66

AUTHORITY

Texas Labor Code §413.031 (c) In resolving disputes over the amount of payment due for medically necessary services for treatment of the compensable injury, the role of the medical fee dispute resolution program is to adjudicate the payment given the relevant statutory provisions and commissioner rules.

Rule at 28 Texas Administrative Code §133.307 sets out the process for medical fee dispute resolution applicable to requestors, respondents, and the Division.

Claim Adjustment Reason Codes
The insurance carrier reduced payment for the disputed service with the following claim adjustment reason codes:

1. Explanation of Benefits (EOB) issued November 29, 2017 and February 6, 2018 both noted:
   - CAC-P12 Workers compensation jurisdictional fee schedule adjustment
   - CAC-W3 This bill has been identified as a request for reconsideration
   - CAC-193 Original payment decision is being maintained.

- CAC-45 Charge exceeds fee schedule maximum allowable or contracted/legislated fee arrangement
- PC4 Payment reduced to Cypress Care contracted rate
- 420 Supplemental payment
- 790 This charge was reimbursed in accordance to the Texas Medical Fee Guideline
- 891 No additional payment after reconsideration

Findings

Injured Workers' Pharmacy billed TMIC, a workers' compensation carrier, for the medication in dispute. TMIC issued an explanation of benefits allowing payment in the amount billed and noted that payment was made directly to Cypress Care. Injured Workers' Pharmacy asserts that it did not receive the payment of $558.66.

It is the insurance carrier's duty to ensure that a complete bill is paid, reduced or denied within 45 days from the date that the carrier recieves that bill. See Texas Labor Code 408.027, and 28 Texas Admininstrative Code §133.240.

In this case, the evidence presented supports that TMIC allowed a payment of $558.66; however TMIC issued payment to its own agent – Cypress Care. Note that in its response to this medical fee dispute, TMIC affirms that Cypress Care is "Texas Mutual's pharmacy benefit manager."

TMIC is ultimately responsible for the actions of its agent. Neither TMIC or its agent provided evidence to support that the payment of $558.66 was issued and received by Injured Workers' Pharmacy in the manner and timeframe required by Texas Labor Code 408.027, and 28 TAC §133.240. For that reason, we find that requested payment is due.

Decision

TMIC is ordered to pay $558.66, plus applicable accrued interest per 28 TAC §134.130.

DIVISION ORDER

The undersigned has been delegated authority by the Commissioner of the Division of Workers' Compensation to sign this official order. The division hereby ORDERS TMIC to pay $558.66 plus interest to Injured Workers' Pharmacy within 30 days of receipt of this order.

Authorized Signature

		April 10, 2019
Signature	Medical Fee Dispute Resolution Director	Date

RIGHT TO APPEAL

Either party to this medical fee dispute may seek review of this Division decision. To appeal, submit form DWC Form-045M titled ***Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)*** found at https://www.tdi.texas.gov/forms/form20numeric.html.

Follow the instructions on pages 3 and 4. The request must be received by the division within twenty days of your receipt of this decision. This decision becomes final if the request for review of this decision is not timely made.

The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

If you have questions about the DWC Form-045M, please call CompConnection at 1-800-252-7031, Option 3 or you may email your question to CompConnection@tdi.texas.gov

Si préfère hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, Option 1.