TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
EZ SCRIPTS LLC

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-21-0038-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 9, 2020

REQUESTOR'S POSITION SUMMARY

"We are not contracted with Optum, Tmesys, or Cypress Care but we were paid at the in-network rate."

Amount in Dispute: $402.00

RESPONDENT'S POSITION SUMMARY

"Upon review of the explanation of benefits for the pharmacy Mail My Meds/EZ Scripts, the bill and payment was made in accordance to Cypress Care Contract."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 18, 2019 – October 15, 2019	Oral Medications	$402.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-131 – Claim specific negotiated discount.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - CAC-91 – Dispensing fee adjustment.
   - G01 – This item is reimbursed as a generic prescribed drug.
   - PC4 – Payment reduced to Cypress Care contract rate.

- 891 – No additional payment after reconsideration.
- CAC-18 – Exact duplicate claim/service.
- 878 – Appeal (request for reconsideration) previously processed. Refer to Rule 133.250(H)

Issues

1. Is this dispute subject to dismissal based on network status?
2. Is EZ Scripts, LLC entitled to additional reimbursement for the drugs in question?

Findings

1. EZ Scripts, LLC is seeking reimbursement for drugs dispensed on September 18, 2019, and October 15, 2019. Texas Mutual Insurance reduced payment based on a network contract rate.

   Prescription medication or services may not be directly or through a contract, be delivered through a workers' compensation health care network.[1] The insurance carrier also failed to provide evidence of a voluntary network agreement.

   The DWC concludes that the insurance carrier's denial for this reason is not supported.

2. 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.[2]

   EZ Scripts, LLC is requesting an additional reimbursement of $402.00 for the disputed drugs. EZ Scripts, LLC has the burden to support its request for this amount. EZ Scripts did not demonstrate how it arrived at the requested amount or whether that amount is consistent with the methodology under 28 TAC §134.503 (c) in its position statement.

   After notification by the DWC's medical fee dispute resolution program of the insurance carrier's response and payment, 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

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		December 16, 2020
Signature	Medical Fee Dispute Resolution Officer	Date

[1] Texas Insurance Code §1305.101 (c)
[2] 28 TAC §134.503 (c)

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.