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
M4-21-0039-01

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: $252.35

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
October 9, 2019	Gabapentin 600 mg	$252.35	$252.35

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. 28 Texas Administrative Codes §§134.530 and 134.540 set out the preauthorization requirements for pharmaceutical services.
4. Texas Labor Code §408.0281 sets out the requirements for informal networks for pharmaceutical services.
5. Texas Insurance Code, Chapter 1305 sets out the requirements for certified healthcare networks.
6. 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.
- PC4 – Payment reduced to Cypress Care contract rate.
- 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 the payment of the drug in question subject to network reduction?
2. Is EZ Scripts, LLC entitled to additional reimbursement?

Findings

1. EZ Scripts, LLC is seeking additional reimbursement, in part, for Gabapentin 600 mg tablets dispensed October 9, 2019. Documentation submitted by the requestor indicates that the Texas Mutual Insurance Company reduced payments to a total of $9.61 based on a contract amount.

   Prescription medication may not directly or indirectly be delivered through a workers' compensation health care network.[1] No evidence of an informal network[2] between the pharmacy and the insurance carrier or their agents was provided. Therefore, the DWC concludes that payment of the drug in question is not subject to network reduction.

2. Because Texas Mutual Insurance Company failed to support its denial reason for the service in this dispute, the DWC finds that EZ Scripts, LLC is entitled to reimbursement.

   The reimbursement considered in this dispute is calculated as follows[3]:

   - Gabapentin 600 mg tablets: (2.52620 x 90 x 1.25) + $4.00 = $288.20

   The total allowable reimbursement is $288.20. EZ Scripts, LLC billed $288.00. Texas Mutual Insurance Company paid $9.61. EZ Scripts, LLC requested $252.35. This amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $252.35.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor $252.35, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 31, 2020 Date

[1] TIC §1305.101 (c)
[2] TLC §408.0281
[3] 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.