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
M4-21-0080-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 16, 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: $1,236.67

RESPONDENT'S POSITION SUMMARY

"MAIL MY MEDS is a participant in the Cypress Care Network for RX per PC4 modifier noted on the EOB. Texas Mutual does not access contracts for Pharmacies. MAIL MY MEDS will need to defer questions to the network for any payments applied by the network."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 13, 2019	Lyrica 100 mg	$567.32	$0.00
September 13, 2019	Meloxicam 7.5 mg	$116.42	$0.00
November 7, 2019	Pregabalin 100 mg	$432.34	$427.99
November 7, 2019	Meloxicam 7.5 mg	$120.59	$116.62
	Total	$1,236.67	$544.61

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-P12 – Workers' compensation jurisdictional fee schedule adjustment.

- CAC-131 – Claim specific negotiated discount.
- CAC-91 – Dispensing fee adjustment.
- G01 – This item is reimbursed as a generic prescribed drug.
- PC4 – Payment reduced to Cypress Care contract rate.
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 891 – No additional payment after reconsideration.
- CAC-18 – Exact duplicate claim/service

Issues

1. Did EZ Scripts, LLC forfeit the right to medical fee dispute resolution for date of service September 13, 2019?
2. Is payment of the drug in question subject to network reduction?
3. Is EZ Scripts, LLC entitled to additional reimbursement?

Findings

1. EZ Scripts, LLC is seeking additional reimbursement for drugs dispensed on September 13, 2019.

   The health care provider must request medical fee dispute resolution within one year from the date of service, except if a related compensability, extent of injury, or liability dispute exists; or a dispute regarding medical necessity has been filed.[1] If these exceptions apply, a request for medical fee dispute resolution must be filed within 60 days of the final adjudication of the disputed issue.

   The DWC received the medical fee dispute resolution request on September 16, 2020. This is more than one year after date of service September 13, 2020. The DWC found no evidence to support that final adjudication of an exception applied to this date of service.

   The DWC finds that has waived the right to medical fee dispute resolution for this date of service.

2. EZ Scripts is also seeking additional reimbursement for drugs dispensed on November 7, 2019. Documentation submitted by the requestor indicates that the insurance carrier reduced payment to $214.27 based on a contract amount.

   Prescription medication may not directly or indirectly be delivered through a workers' compensation health care network.[2] No evidence of an informal network[3] 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.

3. 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[4]:

   - Meloxicam 7.5 mg tablets: (3.1687 x 30 x 1.25) + $4.00 = $122.83
   - Pregabalin 100 mg capsules: (8.42733 x 60 x 1.25) + $4.00 = $636.05

   The total allowable reimbursement is $758.88. The insurance carrier paid $214.27. An additional reimbursement of $544.61 is recommended.

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[1] 28 TAC §133.307 (c)(1)
[2] TIC §1305.101 (c)
[3] TLC §408.0281
[4] 28 TAC §134.503 (c)

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 $544.61.

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 $544.61, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		January 14, 2021
Signature	Medical Fee Dispute Resolution Officer	Date

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.