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
MEMORIAL COMPOUNDING PHARMACY

Respondent Name
TPCIGA FOR LUMBERMENS UNDERWRITING ALLIANCE

MFDR Tracking Number
M4-19-0233-01

Carrier's Austin Representative
Box Number 50

MFDR Date Received
SEPTEMBER 17, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The above claimant received medication and the carrier still has not acknowledged receipt of service…The carrier denied the reconsideration based on unresolved issues of extent of injury…Memorial Compounding Pharmacy was never notified of the extent."

Amount in Dispute: $566.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "TPCIGA supports the position statement provided by our medical review vendor Review Med. Please see attached."

Review Med Position Summary: "On 02/02/2018 TPCIGA filed a DWC PLN 11 form to show this claim has a Third Party Recovery applied. All related and covered charges for the work injury should be paid by the claimant until the recovery amount has been exhausted."

Response Submitted by: Texas Property & Casualty Insurance Guaranty Association

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 22, 2017	Pharmacy Services	$566.53	$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.

Background

1. 28 Texas Administrative Code §133.307 effective May 31, 2012 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §417.002, effective September 1, 1993 outlines the process for recovery in third-party settlements.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 215-Based on subrogation of a third party settlement. Denial based on subrogation of a third party settlement. As directed by TDI Division of Workers' Compensation under advisory 2004-02, we have included on this explanation of benefits the amount that is the responsibility of the injured employee.
    - 219-Based on extent of injury.
    - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the insurance carrier's reason for denial of payment supported?

Findings

The insurance carrier initially denied payment for the disputed pharmacy services based upon extent of injury. The respondent wrote "Based on the PLN-11 form, we incorrectly denied the services as not related to the work injury. The charges should have been processed to show the allowance amount in order for the claimant to make payment to the medical provider. TPCIGA is not responsible for issuing the payment." The division finds an extent of injury issue does not exist in this dispute.

Upon reconsideration, the insurance carrier denied payment for the pharmacy services based upon DWC Advisory 2004-02 - Third Party Litigation (Subrogation) Claim Processing.

Texas Labor Code §417.002(a-c), RECOVERY IN THIRD-PARTY ACTION states,

> (a) The net amount recovered by a claimant in a third-party action shall be used to reimburse the insurance carrier for benefits, including medical benefits, that have been paid for the compensable injury. (b) Any amount recovered that exceeds the amount of the reimbursement required under Subsection (a) shall be treated as an advance against future benefits, including medical benefits, that the claimant is entitled to receive under this subtitle. (c) If the advance under Subsection (b) is adequate to cover all future benefits, the insurance carrier is not required to resume the payment of benefits. If the advance is insufficient, the insurance carrier shall resume the payment of benefits when the advance is exhausted.

The Division reviewed the submitted documentation and finds:

- No documentation was submitted to refute the carrier's position that the services in dispute are subject to payment from a third-party settlement; and
- No documentation was found to support that the net amount recovered in the settlement was exhausted, and that the insurance carrier was required to pay benefits.

The Division concludes that the requestor has failed to support that the disputed services are eligible for reimbursement. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00. The Division emphasized that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. Even though all the evidence was not discussed, it was considered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		3/28/2019
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 28 Texas Administrative Code §133.307, 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 Division within **twenty** days of your receipt of this decision. 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.

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 with the Division. **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.