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**
INJURED WORKERS PHARMACY LLC

**Respondent Name**
Texas Mutual Insurance Company

**MFDR Tracking Number**
M4-20-0748-01

**Carrier's Austin Representative**
Box Number 54

**MFDR Date Received**
November 22, 2019

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "… the medication is specifically indicated to by a 'Y' drug per the ODG website."

**Amount in Dispute:** $2,952.65

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| January 11, 2019 | Diclofenac Sodium 3% Gel | $2,952.65 | $2,952.65 |

## *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 §133.10 sets out the requirements for completing medical bills.
2. 28 Texas Administrative Code §133.210 sets out the requirements for medical documentation.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 874 – Documentation does not support the use of the medication in topical form.
   - 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.

**Issues**

1. Did Texas Mutual Insurance Company respond to the medical fee dispute?
2. Is the insurance carrier’s denial of payment based on billing errors supported?
3. Is the insurance carrier’s denial of payment based on lack of documentation supported?
4. Is Injured Workers Pharmacy, LLC entitled to reimbursement for the drug in question?

**Findings**

1. Texas Mutual Insurance Company received the copy of this medical fee dispute on November 27, 2019. If the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.[1]

   As of today, no response has been received from the insurance carrier. We will base this decision on the information available.

2. Injured Workers Pharmacy, LLC is seeking reimbursement for Diclofenac Sodium 3% Gel dispensed on January 11, 2019. Texas Mutual Insurance Company denied the drug, in part, based on billing errors. The documentation submitted does not support the insurance carrier’s denial of payment for this reason.

3. Texas Mutual Insurance Company also denied the disputed drug based on a lack of documentation. The DWC does not require documentation to be submitted with pharmaceutical services. If an insurance carrier needs additional information to process a medical bill, it may submit a request to the health care provider. The request must:[2]

   - Be in writing;
   - Be specific to the bill or the bill's related episode of care;
   - Describe with specificity the information to be included in the response;
   - Be relevant and necessary for the resolution of the bill;
   - Be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
   - the specific reason for the insurance carrier’s request for the information; and
   - include a copy of the medical bill in question.

   The DWC did not receive evidence that the insurance carrier submitted a request for additional documentation as described above. Texas Mutual Insurance Company’s denial of payment for this reason is not supported.

4. Because the insurance carrier failed to support its denial of payment for the disputed drug, Injured Workers Pharmacy, LLC is entitled to reimbursement.

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

   - Diclofenac Sodium 3% Gel: (11.7946 x 200 x 1.25) + $4.00 = $2,952.65

   The total allowable reimbursement is $2,952.65. 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 $2,952.65.

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[1] 28 TAC §133.307(d)(1)
[2] 28 TAC §133.210(d)
[3] 28 Texas Administrative Code §134.503(c)

## *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 $2,952.65, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

| ______________________ | Laurie Garnes | January 16, 2020 |
|---|---|---|
| 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**.