TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MEMORIAL COMPOUNDING RX

Respondent Name
Allmerica Financial Benefit Insurance Company

MFDR Tracking Number
M4-20-1510-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
February 18, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Bill for date of service 10/09/2019 was processed on 11/06/2019. We received the explanation of benefits but there was no reason for reduction or denial."

Amount in Dispute: $67.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have determined that a CorVel, designated vendor, determined on 11/7/2019, through a Retrospect Utilization Review that there was sufficient evidence to provide a denial of the requested medication."

Response Submitted by: Allmerica Financial Benefit Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 9, 2019	Amitriptyline HCl 10 mg Tablets	$67.04	$15.93

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 §133.210 sets out the documentation requirements for medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 080 – Denied per carrier
   - B11 – Not covered by this Payer-Forward to correct Payer

Issues

1. Did the Allmerica Financial Benefit Insurance Company raise a new defense in its response?
2. Is the Allmerica Financial Benefit Insurance Company's denial reason supported?
3. Is Memorial Compounding Rx (Memorial) entitled to additional reimbursement?

Findings

1. In its position statement, Allmerica Financial Benefit Insurance Company argued that "We have determined that a CorVel, designated vendor, determined on 11/7/2019, through a Retrospect Utilization Review that there was sufficient evidence to provide a denial of the requested medication."

   The response from the insurance carrier is required to address only the denial reasons presented to the health care provider before to the request for medical fee dispute resolution (MFDR) was filed with the DWC. Any new denial reasons or defenses raised shall not be considered in this review.[1]

   The submitted documentation does not support that a denial based on medical necessity was provided to Memorial before this request for MFDR was filed. Therefore, the DWC will not consider this argument in the current dispute review.

2. Memorial is seeking reimbursement for Amitriptyline HCl 10 mg tablets dispensed on October 9, 2019. Allmerica Financial Benefit Insurance Company denied the dispensed drug stating that the charge was "not covered by this Payer."

   Submitted documents indicated that Memorial sent the bill in question to "HANOVER INS." Documents submitted by the insurance carrier show that Hanover Insurance Group is a third party administrator for the insurance carrier, Allmerica Financial Benefit Insurance Company. Based on all available information, the DWC finds that Allmerica Financial Benefit Insurance Company is the insurance carrier for this claim.

   It is the insurance carrier's obligation to provide its agents with any documents needed to process a medical bill. The DWC considers any medical billing information or documents possessed by one entity to be simultaneously possessed by the other.[2]

   The DWC concludes that the insurance carrier's denial of payment is not supported.

3. Because Allmerica Financial Benefit Insurance Company failed to support its denial reason for the service in this dispute, the DWC finds that Memorial is entitled to reimbursement.

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

   - Amitriptyline 10 mg tablets: (0.318 x 30 x 1.25) + $4.00 = $15.93

   The total allowable reimbursement is $15.93. 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 $15.93.

[1] 28 TAC §133.307 (d)(2)(F)
[2] 28 TAC §133.210 (e)
[3] 28 TAC §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 $15.93, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	March 12, 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.