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
TASB RISK MGMT FUND

MFDR Tracking Number
M4-20-1701-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
March 9, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the medication stating the treatment requires pre-authorization prior to shipping. This medication, however, is a 'Y' status drug per the Texas ODG Formulary so it does not require authorization prior to shipping."

Amount in Dispute: $1,478.33

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
November 29, 2018	Diclofenac Sodium 3% Gel	$1,478.33	$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 (DWC). 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

Issues

1. Did TASB Risk Management Fund respond to the medical fee dispute?
2. Did Injured Workers Pharmacy, LLC forfeit its right to medical fee dispute resolution for the date of service in question?

Findings

1. The Austin insurance carrier representative for TASB Risk Management Fund is Burns, Anderson, Jury & Brenner. The representative received the copy of this medical fee dispute on or about March 17, 2020. 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 or its representative. We will base this decision on the information available.

2. Injured Workers Pharmacy, LLC is seeking reimbursement for Diclofenac Sodium 3% Gel dispensed on November 29, 2018.

   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.[2] 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 March 9, 2020. This is more than one year after date of service November 29, 2018. The DWC found no evidence to support that final adjudication of an exception applied to this date of service.

   The DWC finds that Injured Workers Pharmacy, LLC has waived its right to medical fee dispute resolution for this date of service.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		May 27, 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.

[1] 28 TAC §133.307(d)(1)
[2] 28 TAC §133.307 (c)(1)