TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

# Medical Fee Dispute Resolution Findings and Decision

## General Information

**Requestor Name**
Memorial Wellness Pharmacy

**Respondent Name**
Massachusetts Bay Insurance Company

**MFDR Tracking Number**
M4-24-2061-01

**Carrier's Austin Representative**
Box Number 47

**DWC Date Received**
May 23, 2024

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| October 10, 2023 | Prescription medication | $202.85 | $0.00 |
| | **Total** | $202.85 | $0.00 |

## Requestor's Position

"The above claimant received medication and the carrier still has not acknowledged receipt of service. The original bill was submitted to the carrier on 10/20/2023 VIA CERTIFIED MAIL. The Texas Labor Code Section 408.027(b) requires that the carrier must pay, reduce, deny or determine to audit the health provider's claim no later than the 45th day after the date of receipt by the carrier. Memorial did not receive any correspondence as per Rule 133.250(a), so we submitted a Request for Reconsideration. The reconsideration was submitted and received by the carrier on 01/11/2024 VIA CERTIFIED MAIL but denied. I have attached proof of submission for both correspondences."

**Amount in Dispute:** $202.85

## Respondent's Position

"... the claimant has received a 3rd party settlement in the amount of $70,000.00 in this case. This settlement was received by the claimant in 2020. Because of this, no additional medical bills will be processed under the workers' comp claim until the claimant has shown that she has exhausted the settlement amount in medical bills related to the work injury."

**Response Submitted by:** The Hanover Insurance Group

# Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. TLC §417.002 outlines the process for recovery in third-party settlements.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- D3(P12) – The charge for the prescription drug is greater than the maximum reimbursement for a generic drug.
- D3 – Workers' compensation jurisdictional fee schedule adjustment.
- TERM – Date of Service after Coverage expired.
- 60(B13) – The provider has billed for the exact services on a previous bill.
- HNDS – Claim has resolved no further benefits per settlement agreement.
- B13: 60 – Previously paid. Payment for this claim/service may have been provided in a previous payment.

Issues

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

Findings

1. The dispute concerns the non-payment of prescription medication rendered on October 10, 2023, and billed under NDC No. 29300-0125-10. The requestor is seeking a total reimbursement amount of $202.85.

   Texas Labor Code §417.002(a-c), *Recovery in Third-Party Action*, states,

   > 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 service in dispute is subject to payment from a third-party settlement; and
- No documentation was found to support the fact that the net amount recovered in the settlement was exhausted.

The Division concludes that the requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requestor has not established that reimbursement is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to reimbursement for the disputed services. It is ordered that the respondent must remit to the requestor $0.00 for the disputed services.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | September 30, 2024<br>Date |
|---|---|---|

## Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.