

**GETTING WHAT YOU NEED -
OBTAINING PRESCRIPTION MEDICATION
FOR THE INJURED TEXAS WORKER**

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“The minute you read something you can’t understand,
you can almost be sure it was drawn up by a lawyer”

Will Rogers

*. . . "I went down to the Chelsea drugstore
To get your prescription filled
I was standing in line with Mr. Jimmy
And man, did he look pretty ill
We decided that we would have a soda
My favorite flavor, cherry red
I sung my song to Mr. Jimmy
Yeah, and he said one word to me, and that was "dead"
I said to him*

*You can't always get what you want, no!
You can't always get what you want (tell ya baby)
You can't always get what you want (no)
But if you try sometimes you just might find
You get what you need . . ."*

You Can't Always Get What you Want - The Rolling Stones

We have all been in the situation where your client is at the pharmacy attempting to get their prescription filled. The pharmacist has refused to fill the prescription because of previously unpaid bills by the workers' compensation insurance carrier. This article will try to assist the injured worker in "getting what you need" by explaining how to get the injured worker reimbursed for out of pocket prescription medication expenses.

INITIAL CONSIDERATIONS BEFORE REQUESTING REIMBURSEMENT

The prescription medication must be provided for a compensable injury. Disputes over compensability and extent of injury must be resolved prior to requesting reimbursement from the insurance carrier. TAC Section 133.270.

In the event that the employer has elected to participate in a network, the prescription must be written by a network provider. If the employee obtains health care for non-network providers without network approval, the injured employee and not the insurance carrier may be liable for payment of that health care. Texas Ins. Code Section 1305.451

The injured employee must have paid for the prescription medication. The injured employee must actually incur the expenses before requesting reimbursement from the carrier or requesting a medical fee dispute. TAC Section 133.270.

The employee must have paid for generic drug when available. The employee may chose to receive a brand name drug rather than a generic alternative but the employee is liable for the difference in cost between the brand name and the generic alternative. The employee is not entitled to reimbursement from the insurance carrier for the difference in costs. TAC Section 134.504 (b).

REQUEST REIMBURSEMENT FROM THE INSURANCE CARRIER.

Submit to the insurance carrier a letter requesting reimbursement. The letter must include information that clearly identifies the claimant such as the claimant's name, address, date of injury and social security number. TAC Section 133.270 (b).

The request must include the receipt indicating the amount paid. The receipt should also include documentation concerning the prescription such as the prescribing health care provider's name, the date the prescription was filled, the name of the drug, and the dollar amount paid by the employee. Cash register receipts alone are not acceptable. TAC Section 134.504 (a)(1).

Although not required the request should be sent via verifiable means. Either a facsimile transmission certification page or certified mail return receipt request would be acceptable.

CARRIER'S OBLIGATIONS UPON RECEIPT OF THE REIMBURSEMENT REQUEST

The carrier shall make appropriate payment to the injured employee or notify the injured employee of a reduction or denial or payment within 45 days of receipt of the request. TAC 133.270(c).

If the insurance company does not pay the full amount or denies reimbursement, the carrier must include a full and complete explanation of the reason(s) the insurance carrier has reduced or denied payment. The statement shall include sufficient claim specific information to enable the employee to understand the insurance carrier's position and action on the claim. TAC Section 134.504.

If the insurance company does not pay the full amount or denies reimbursement, the insurance carrier must also inform the injured employee of his or her right to request medical dispute resolution. TAC Section 134.504.

GENERAL INFORMATION REGARDING MEDICAL DISPUTE RESOLUTION (MDR)

If the insurance company has reduced or denied payment of the reimbursement request, the injured worker may proceed to medical dispute resolution (MDR). TAC Section 133.305.

The injured employee may request, but is not required to request, reconsideration prior to requesting medical dispute resolution. TAC Section 133.270 (f). If the injured worker has

failed to submit all required information then consider resubmitting the request with the additional documentation. Otherwise the injured worker should proceed to MDR.

MDR is a process for resolving medical fee disputes and medical necessity disputes. TAC Section 133.305 (a)(3).

Medical fee disputes are generally those that involve the amount of payment for a particular medical service rather than the reasonableness and necessity of that care. An employee dispute of a reduction of a refund request for health care charges paid for by the employee would be a medical fee dispute. TAC 133.305 (a)(4)(B).

Medical necessity disputes involve the medical necessity of health care are either prospective or retrospective depending on whether the care has been provided or not. A dispute that involves a review of the medical necessity that has already been provided is referred to as a retrospective medical necessity dispute. TAC 133.305(a)(8).

RESOLVING RETROSPECTIVE MEDICAL NECESSITY DISPUTES

If the carrier has disputed the necessity of the prescription medication the injured worker may request MDR. TAC 133.308(d)(1)(B); TAC 133.308(d)(2)(B).

Retrospective medical necessity disputes will be resolved by appointment of an independent review organization (IRO) to review the medical bills to determine medical necessity.

The injured worker must file the request for MDR no later than the 45th calendar day after receipt of the insurance carrier's denial of reimbursement. TAC 133.308(g)

The request for MDR must be on a form LHL009 "Request for Review by an Independent Review Organization."

The injured worker shall file the request with the insurance carrier or the carrier's utilization review agent (URA). TAC 133.308(g).

Again, although not technically required the injured employee should send the request by certified mail, return receipt requested or via facsimile transmission to verify the carrier's timely receipt of the request.

The carrier shall immediately notify the Texas Department of the request for medical dispute resolution. TAC 133.308(g).

The Texas Department of Insurance shall assign an IRO and notify the parties of the IRO assignment. TAC 133.308(i).

Not later than the third day after receipt of the request for the IRO, the insurance carrier is required to submit the following documentation to the IRO: the request for the IRO, all medical

records of the employee relevant to the dispute, all documents policies and guidelines that the carrier used in making the decision, all documentation submitted to the carrier in support of the appeal, written notification of the denial of the request for reimbursement, any other information required by the TDI. TAC 133.308(j).

In all disputes involving reimbursement of medical treatment paid for by the injured employee the insurance carrier shall pay the IRO fee within 15 days after receipt of an invoice by the IRO. TAC 133.308(p)(2)(A).

The IRO will determine retrospective medical necessity disputes no later than the 30th day after the IRO receives the IRO fee. TAC 133.308(m)(3).

MEDICAL FEE DISPUTES

If the insurance carrier has reduced the amount of reimbursement the injured worker may request medical fee dispute resolution by filing a DWC Form number 60.

The injured employee must include a description of the health care, why the disputed amount should be reimbursed and how the submitted documentation supports the explanation for each disputed amount.

The injured employee must also include the proof of payment (receipt) and the denial of the reimbursement.

The Texas Department of Insurance will forward a copy of the request for medical fee dispute to the carrier who has 14 days to provide a written response. If no response is received within 14 days the TDI may base its decision on the available information.

The Texas Department of Insurance will review the completed request and response to determine the appropriate MDR action. The Texas Department of Insurance may request additional information, raise issues appropriate to the administration of the disputes or dismiss the request.

The Texas Department of Insurance shall issue and decision and notify the parties of the decision. A party wishing to appeal the decision of the Texas Department of Insurance may seek judicial review by filing a petition in Travis County district court not later than 30 days after the date on which the decision is received by the appealing party.