

# Prescription Reimbursement

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Information for Employees from the Division of Workers' Compensation

## Request for Payment

[Tex. Admin. Code §§133.270, 134.503 and 134.504]

If you purchased prescription drugs or over-the-counter alternatives, prescribed or ordered by a doctor treating you for your work-related injury or illness; you may request reimbursement from the insurance carrier responsible for your workers' compensation claim.

You are not entitled to reimbursement from the insurance carrier for the difference in cost between generic and brand name drugs if a generic drug was available and you chose to purchase the brand name.

## Request for Reimbursement

To receive reimbursement for your out-of-pocket expenses, you must submit a request for reimbursement to the insurance carrier. The request should be submitted as soon as possible after the date(s) you purchased the prescription(s) or over-the-counter alternatives. The request must include:

- a letter that clearly identifies:
- your name;
- your address;
- your date of injury;
- your social security number;
- documentation concerning the prescription(s), that includes:
- your name;
- prescribing doctor's name;
- name of the drug;
- date the prescription was filled by the pharmacy; and
- the dollar amount you paid for the prescription(s); and
- a receipt showing the amount you paid for the prescription.

You may submit a copy of the information sheet provided by the pharmacy or a print out of your work-related prescriptions for a particular time period from the pharmacy with the request for reimbursement letter. Cash register receipts alone are not sufficient to support your request.

## Response to the Request for Reimbursement

The insurance carrier must respond to your request for reimbursement within 45 days of the date the insurance carrier receives your request. The insurance carrier will either pay you or notify you in writing of the reasons for any reduction or denial of reimbursement.

## Denial of Request for Reimbursement

[Tex. Admin. Code §§133.307, 133.308 and 141.1]

If the insurance carrier denies your request for reimbursement, you can request dispute resolution from the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC).

## Medical Necessity Dispute

If the denial of your request for reimbursement states the prescriptions, or over-the-counter alternatives are not medically necessary, you can request a review by an Independent Review Organization (IRO) by completing a form LHL009, Request for Review by an IRO, and submitting the form to the Utilization Review Agent (URA) company that denied the request for reimbursement.

## Compensability/Extent of Injury/Liability Dispute

If the denial of your request for reimbursement states the prescriptions or over-the-counter alternatives are for an unrelated or a non-compensable (payable) condition, or states that the insurance carrier is not liable for the claim, you can request a Benefit Review Conference (BRC) by calling your local TDI-DWC field office at 1-800-252-7031 or completing a DWC Form-045, *Request to Schedule, Reschedule or Cancel a Benefit Review Conference (BRC)*, and submitting the form to your local TDI-DWC field office. A TDI-DWC employee from your local field office will process your request for the BRC.

A BRC is an informal meeting where an injured employee will meet with someone from the insurance company to discuss and try to resolve the disputed issues in front of a Benefit Review Officer, who is a TDI-DWC employee. If all issues are not resolved another proceeding may be scheduled.

**For further assistance,  
call 1-800-252-7031 or visit**

**<http://www.tdi.texas.gov/wc/employee/index.html>**

## Medical Fee Dispute

If the denial of your request for reimbursement pertains to the amount of money you have requested to be reimbursed and not to medical necessity, compensability, extent of injury, or liability, you may request medical fee dispute resolution. You must send the following information to the TDI-DWC, Medical Fee Dispute Resolution, no later than one year after the date(s) you purchased the prescription(s) or over-the-counter alternatives:

- a completed DWC Form-060, *Medical Fee Dispute Resolution Request/Response*;
- a copy of the letter you received from the insurance carrier in response to your request;
- an explanation from you stating why the insurance company should pay the reimbursement or pay the full amount of the prescription(s);
- proof that you paid for the prescriptions or over-the-counter alternatives; and
- a second copy of all of the above.

The DWC Form-045, DWC Form-060 and form LHL009 can be downloaded from the TDI website at <http://www.tdi.texas.gov/forms/form20.html> or you can contact your local TDI-DWC field office to request a form be mailed to you.

For IRO information visit the TDI website at: <http://www.tdi.texas.gov/hmo/mcqa/indexiro.html>.

For benefit review conference information for injured employees visit the TDI website at <http://www.tdi.texas.gov/pubs/factsheets/dispute.pdf>.

For medical fee dispute resolution information for injured employees, visit the TDI website at <https://www.tdi.texas.gov/wc/mfdr/index.html>.

## Requesting Dispute Resolution

Reason for Denial of Reimbursement	What Form to Use	Where to Send Form
Not liable, Not Compensable or Unrelated to the Injury	DWC Form-045, <i>Request for a Benefit Review Conference</i>	Local TDI-DWC Field Office
Not Medically Necessary	LHL009, <i>Request for Review by an IRO</i>	Utilization Review Agent (working for the insurance carrier)
Fee Denials (other than the above reasons)	DWC Form-060, <i>Medial Fee Dispute Resolution Request/Response</i>	TDI-DWC Medical Fee Dispute Resolution