TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Injured Workers Pharmacy LLC

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-25-0349-01

Carrier's Austin Representative
Rep Box 45

DWC Date Received
October 11, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 14, 2023	NDC # 59676036001	$1,879.67	$1,879.67

Requestor's Position

"The carrier denied the ORTHOVISC 15 MG/ML SYRINGE for no pre-authorization/pre-certification. The EOB also mentioned that medicals were needed to substantiate how the treatment was related to the work injury."

Amount in Dispute: $1,879.67

Respondents' Position

"Upon notification of this dispute, the Office researched the medical billing received from Injured Workers Pharmacy which determined that our denial for 197 will be maintained as the documentation does not support how the ODG supports this injection to treat the compensable injury."

Response Submitted by: State Office of Risk Management

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §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 general procedures for medical dispute resolution.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §134.503 sets out the fee guidelines for pharmacy.

Denial Reasons

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

- 197 – Payment denied/reduced for absence of precertification/preauthorization.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable.
- Note: Need documentation to support the necessity of the medication and how it's related to the WC injury.

Issues

1. Is the denial due to lack of preauthorization supported?
2. Is the requester entitled to reimbursement?

Findings

1. The insurance carrier in their position summary states, "Upon notification of this dispute, the Office researched the medical billing received from Injured Workers Pharmacy which determined that our denial for 197 will be maintained as the documentation does not support how the ODG supports this injection to treat the compensable injury."

   The requestor is seeking reimbursement in the amount of $1,879.67 for a prescription dispensed on December 14, 2023. The insurance carrier is denying reimbursement due to the absence of preauthorization.

   A review of Appendix A ODG formulary finds preauthorization is not required for the medication in dispute. Because the insurance carrier's denial due to lack of preauthorization is not supported, the requestor is entitled to reimbursement for the medication in dispute.

2. 28 TAC §134.503 (c) states the insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally

recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:

- Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

Drug	NDC	Generic(G) / Brand(B)	Price / Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed Amt
Orthovisc 15 mg/ml	59676036001	B	286.800	6	$1,879.67	$1,879.67	$1,879.67

The total reimbursement is $1,879.67. This amount is recommended.

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.

DWC finds the requester has established that reimbursement of $1,879.67 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the respondent must remit to the requestor $1,879.67 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		February 4, 2025
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 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.