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
Injured Workers Pharmacy LLC

Respondent Name
Travis County

MFDR Tracking Number
M4-25-1308-01

Carrier's Austin Representative
Rep Box 19

DWC Date Received
February 13, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 25, 2024	NDC # 00456120130 Linzess	$711.52	$711.52

Requestor's Position

"An appeal was submitted explaining that the medication LINZESS 145 MCG CAPSULE is not an 'N' status medication, so would not require authorization prior to filling. The medication was not created through compounding nor is it an investigational or experimental drug for treatment. I asked they please review again pule rule 134.500 which states that that closed formulary consists of all available FDA approved prescription and non-prescription drugs prescribed and dispensed for outpatient use. LINZESS 145 MCG CAPSULE is FDA approved and not excluded from the formulary, therefore; it would not require UR approval prior to filling."
Amount in Dispute: $711.52

Respondents' Position

"The prescription was denied on the basis of lack of preauthorization."
Received by: Flahive, Ogden & Latson

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 §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.

4. 28 Texas Administrative Codes §§134.530 and 134.540 sets out the closed formulary requirements, effective January 17, 2011, 35 TexReg 11344.

Denial Reasons

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

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CA_G57 – Service or procedure requires prior authorization and none was identified.
- 18 – Exact duplicate claim/service.

Issues

1. Is insurance carrier's denial reason(s) supported?

2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement in the amount of $711.52, for prescribed medication, Linzess dispensed on July 25, 2024. The insurance carrier is denying reimbursement due to the denial reasons indicated above. Review of the applicable Appendix A found the disputed medication, Linzess is not listed on this formulary.

   The DWC rule applicable to medication not included in the formulary or in Appendix A is,

   Pharmacy Fee Guidelines: Texas Administrative Code Rule 134.530 and 134.540
   Consistent with Texas Labor Code 413.014, and Texas Labor Code 413.017, the DWC applicable rules plainly state that preauthorization is **only** required for: (1)drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) /

Appendix A, ODG Workers' Compensation Drug Formulary, and any updates; (2)any compound that contains a drug identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates; and (3)any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

The DWC finds that the drug in question does not require preauthorization. The DWC concludes that the insurance carrier's denial of payment of the disputed drug based on preauthorization is not supported. The requestor is therefore 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;
    - (B) Brand-name drugs: ((AWP per unit) x (number of units) x 1.09) + $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
Linzess	00456120130	B	21.63667	30	$711.52	$711.52	$711.52

The total reimbursement is $711.25. 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 requestor has established that reimbursement of $711.52 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement. It is ordered that the respondent must remit to the requestor $711.52 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 3, 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.