



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Injured Workers Pharmacy

Respondent Name

Texas Municipal League Intergovernmental Risk Pool

MFDR Tracking Number

M4-25-2246-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

May 15, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 12, 2024	NDC - 16714087801	\$3,743.05	\$3,743.04

Requestor's Position

Initial Statement: "Carrier denied bills due to an 'unauthorized prescriber'. This doctor has been confirmed to be authorized on the claim based on the paid responses on the medications this prescriber."

Subsequent Statement: "In response to the letter we received, the MFDR stands.

"The EOBs state services not provided by network/primary care providers, we have multiple prescribers on this claim and they are all at the same office."

Amount in Dispute: \$3,743.05

Respondent's Position

"The services have been denied. This is explained in the carrier's EOB. The provider is not entitled to reimbursement."

Response Submitted by: Flahive, Ogden & Latson

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 \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.503](#) sets out the fee guidelines for pharmaceutical services.
3. 28 TAC §§[134.530](#) and [134.540](#) set out the preauthorization requirements for pharmaceutical services.
4. [Texas Insurance Code \(TIC\) §1305](#) sets out the requirements for workers' compensation health care networks.

Denial Reasons

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

- 230 – Treatment not authorized.
- 242 – Services not provided by network/primary care providers.
- Note: "LIDOCAINE WAS APPROVED BY OPTUM AND PAID TO THEM ON 7/16/2024, YOUR DOS WAS NO AUTHORIZED FOR PAYMENT."

Issues

1. Is the insurance carrier's denial based on network status supported?
2. Is the insurance carrier's denial based on preauthorization supported?
3. Is the insurance carrier's denial based on payment to a different provider supported?
4. Is Injured Workers Pharmacy entitled to reimbursement for the drugs in question?

Findings

1. Injured Workers Pharmacy is seeking reimbursement for Lidocaine 5% Ointment dispensed on July 12, 2024. The insurance carrier denied payment, in part, based on network status.

Per TIC §1305.101 (c), prescription medication or services may not, directly or through a contract, be delivered through a workers' compensation health care network.

DWC concludes that the disputed prescription medication dispensed by the provider in this case – Injured Workers Pharmacy – is not subject to the provisions of a workers’ compensation health care network. Therefore, the insurance carrier’s denial for this reason is not supported.

2. The insurance carrier also denied the billed amount, in part, stating “TREATMENT NOT AUTHORIZED.” Per 28 TAC §134.530(b)(1) and §134.540(b), preauthorization is only required for:

- drugs identified with a status of “N” in the current edition of the ODG Appendix A;
- any compound prescribed before July 1, 2018, that contains a drug identified with a status of “N” in the current edition of the ODG Appendix A;
- any prescription drug created through compounding prescribed and dispensed on or after July 1, 2018; and
- any investigational or experimental drug.

DWC finds that Lidocaine is not identified with a status of “N” in the applicable edition of the ODG, *Appendix A*. Therefore, this drug does not require preauthorization for this reason.

The submitted documentation does not identify the disputed drug as a compound. Therefore, this drug does not require preauthorization for this reason.

The submitted documentation does not identify the disputed drug as experimental or investigational. Therefore, this drug does not require preauthorization for this reason.

DWC concludes that the insurance carrier’s denial of payment of the disputed drug based on preauthorization is not supported.

3. The insurance carrier also denied the drug in question stating, “LIDOCAINE WAS APPROVED BY OPTUM AND PAID TO THEM ON 7/16/2024, YOUR DOS WAS NO AUTHORIZED FOR PAYMENT.” However, the insurance carrier failed to provide any documentation to support this denial reason.
4. Because the insurance carrier failed to support its denial reasons for the drug in question, DWC finds that Injured Workers Pharmacy is entitled to reimbursement.

The reimbursement considered in this dispute is calculated according to 28 TAC §134.503(c)(1)(A), with relevant formula for generic drugs: ((AWP per unit) x (number of units) x 1.25) + \$4.00 dispensing fee per prescription = reimbursement amount.

Date	Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
7/12/2024	Lidocaine 5% Ointment	16714087801	G	\$7.67297	389.84	\$3,743.04	\$3,743.05	\$3,743.04

The total allowable reimbursement is \$3,743.04. 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 \$3,743.04 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 Texas Municipal League Intergovernmental Risk Pool must remit to Injured Workers Pharmacy \$3,743.04 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	June 25, 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, please call CompConnection at 1-800-252-7031, option three 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 tres o correo electrónico CompConnection@tdi.texas.gov.