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

General Information

Requestor Name
Memorial Compounding RX

Respondent Name
State Farm Fire & Casualty Co

MFDR Tracking Number
M4-21-1913-01

Carrier's Austin Representative
Box Number 1

DWC Date Received
June 28, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 7, 2021	Meloxicam	$202.85	$0.00
May 7, 2021	Omeprazole	$158.70	$130.49
May 7, 2021	Cyclobenzaprine	$106.72	$0.00
May 7, 2021	Tramadol	$81.39	$0.00
May 7, 2021	Duloxetine	$267.20	$0.00
	Total	$816.86	$130.49

Requestor's Position

The above claimant received medication and carrier denied the request indicating that the bill has been returned, as an alternate vendor. Memorial Compounding Pharmacy does not have a contract with the alternate vendor; therefore, claim should be process by the direct carrier.

Amount in Dispute: $816.88

Respondent's Position

Requester submitted medical bills for prescriptions provided to Claimant, (redacted). Carrier properly reviewed the bills. Please see attached Explanation of Benefits (EOBs).

Response Submitted by: State Farm Fire & Casualty Company

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.503 sets out the fee guidelines for pharmacy.

Denial Reasons

1. The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

    - PPO Reduction: Paid in accordance with a Optum PBM Pass Thru Contract

Issues

1. Is the insurance carrier's reduction supported?
2. What rule(s) apply to disputed services?

Findings

1. The insurance carrier reduced the payment amount based on a PPO contract. Insufficient evidence was found to support the injured worker is enrolled in a certified network or support of a contract. The disputed services will be reviewed per applicable fee guideline.
2. The requestor is seeking reimbursement for oral medication dispensed May 7, 2021. The insurance carrier provided evidence of a payment made June 10, 2021, in the amount of $551.20. The medications will be reviewed per applicable fee guideline.

    28 Texas Administrative Code §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
Meloxicam	68382005105	G	4.84	30	$185.68	$202.85	$185.68
Omeprazole	62175011843	G	3.37	30	$130.50	$158.70	$130.50
Cyclobenzaprine	52817033050	G	1.64	30	$65.52	$106.72	$65.52
Tramadol	57664037718	G	0.796	30	$33.86	$81.39	$33.86
Duloxetine	31722058160	G	6.99	30	$266.13	$267.20	$266.13

The total allowed reimbursement is $681.69. The insurance carrier provided evidence of payment of $551.20. Additional payment of $130.49 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 additional reimbursement of $130.49 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is [not] entitled to additional reimbursement for the disputed services. It is ordered that State Farm Fire & Casualty Co must remit to Memorial Compound Rx $130.49 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		September 30, 2021
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 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.