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

Requester Name
Memorial Compounding RX

Respondent Name
State Farm Fire & Casualty Co

MFDR Tracking Number
M4-21-2207-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
July 30, 2021

Requester's Position

After reviewing the explanation of benefits it indicates that the alternate vendor, TMESYS paid $551.20 and not full amount of $816.86. This claim should be processed with the full amount billed as per Administrative Labor Code 134.503 (c).

Amount in Dispute: $158.70

Respondent's Position

Requestor seeks reimbursement of one medication, Omeprazole. Pursuant to the Explanation of Benefits attached to Requestor's DWC60, the charge for this medication was denied pursuant to the fee guidelines. Requestor offered no justification for reimbursement of this prescription. Carrier asserts that the bill was properly processed.

Response Submitted by: Smith & Carr P.C.

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 4, 2021	Oral medication	$158.70	$130.50
	Total	$158.70	$130.50

Findings and Decision

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).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.

Issues

1. Is the respondent's position statement supported?

2. What rule(s) apply to disputed services?

Findings

1. The requestor is seeking reimbursement for oral medication dispensed June 4, 2021. The insurance carrier states in their position statement the medication was denied based on the workers' compensation fee schedule. Review of the submitted explanation of benefits found the "ANSI Reason Code" column for this medication is blank.

   The reviewed explanation of benefits was insufficient to support the medication in dispute was adjudicated for payment or denial. The respondent's position statement is not supported.

   The medication will be reviewed per applicable fee guideline.

2. DWC Rule 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
Omeprazole	62175011843	G	3.37	30	$130.50	$158.70	$130.50

The total reimbursement is $130.50. This amount is recommended.

Conclusion

DWC finds that the requester established that additional reimbursement is due. As a result, the amount ordered is $130.50.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that State Farm & Casualty Co must remit to Memorial Compounding RX $130.50 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		August 31, 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 512-804-4812.