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

General Information

Requester Name
Injured Workers Pharmacy

Respondent Name
State Farm Fire & Casualty Co

MFDR Tracking Number
M4-25-2968-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
July 21, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 4, 2024	69097012303	$1,138.50	$1,138.49
March 21, 2025	69097012303	$1,138.50	$1,138.49
		$2,277.00	$2,276.98

Requester's Position

"A Medical Fee Dispute Resolution request has been submitted for invoices not paid by Sedgwick for the medication TOPIRAMATE 50 MG TABLET, NDC 69097012303 (DOS 9/4/24 and 3/21/25). The medication was pre-authorized and approved by Sedgwick's UR team, yet they continue to deny for no authorization or for the medication not being approved – even though the adjuster has confirmed on several occasions it is authorized."

Supplemental response September 8, 2025

"There were several Utilization Review approvals. Typically Sedgwick will not send a copy of the actual UR and just gives us the information verbally. …I just called Sedgwick UR and they are faxing me over a copy of the UR for 3/21/25."

Amount in Dispute: $2,277.00

Respondent's Position

"Requestor filled the medication, Topiramate, two times: once on 9/04/2024 and again on 3/21/2025. The preauthorization for the medication plus one refill expired on 2/13/2025. Respondent is currently pay for the medication filled on 9/04/2025 per the preauthorization approval letter. However, there was no preauthorization approval as required for the medication filled on 3/21/2025. Requestor failed to have the approval extended and is not owed for the medication filled on 3/21/2025."

Response submitted by: Downs & Stanford

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 services.

Denial Reasons

- 9D – (P12) – The charge for the Closed Formulary Drug requires Prior Authorization as defined within Texas Administrative Code Chapter 134, Section 134.530 and 134.540. If prior Authorization was obtained, please submit with a copy of the required information.
- HE70 – Product/Service Not Covered
- VL(B13) – The provider has billed for the exact services on a previous bill under review and in-progress
- 247 – A payment or denial has already been recommended for this service
- 18 – Exact duplicate claim/service

Issues

1. Is the insurance carrier's denial supported?
2. What rule is applicable to reimbursement?
3. Is the requester entitled to reimbursement?

Findings

1. The requester seeks reimbursement of the medication Topiramate for dates of service

September 4, 2024 and March 21, 2025. The insurance carrier denied for lack of required authorization.

Documents submitted with this request for MFDR included a letter from Sedgwick dated September 4, 2024 that approved Topiramate 50mg 1 tab bid for 30 days #180 x1 refill. The start date was August 13, 2024. The end date was February 13, 2025. A Sedgwick letter dated March 18, 2025 that approved Topiramate 50mg 1 tab bid for 90 days #180 x3 refills with a start date of March 11, 2025 and end date of March 2026 was supplementally added. Based on these documents, the insurance carrier's denial for lack of prior authorization is not supported.

2. The service in dispute will be reviewed per the applicable fee guidelines. 28 TAC §134.503 (c) (1) (A) states in pertinent part, 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 or the billed amount.

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

The calculation of the total allowable amount is as follows:

Drug Name	NDC No.	Generic (G) Brand (B)	Price/Unit	AWP	Billed Amount	Lesser of AWP and Billed Amount
Topiramate	69097012303	G	5.04/180	$1,138.49	$1,138.50	$1,138.49

3. The DWC finds that the requester is entitled to reimbursement in the amount of $1,138.49 for the dates of service September 4, 2024 and March 21, 2025 for a total of $2,276.98. In their response to MFDR, the respondent indicates a payment for date of service September 4, 2024 was to be made. At the time of this review, insufficient evidence was found to support a payment made for the disputed dates of service.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the Injured Workers Pharmacy has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled

to reimbursement for the disputed services. It is ordered that State Farm Fire and Casualty Co must remit to Injured Workers Pharmacy $2,276.98 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		September 12, 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 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.