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
Memorial Wellness Pharmacy

Respondent Name
Great Divide Insurance Co

MFDR Tracking Number
M4-24-1780-01

Carrier's Austin Representative
Rep Box 47

DWC Date Received
April 16, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 11, 2023	NDC # 49483-0699-01 Acetamin Tab 650 mg	$72.18	$15.48
July 11, 2023	NDC # 71093-0161-05 Gabapentin Cap 100mg	$73.40	$23.88
July 11, 2023	NDC # 59651-0362-05 Ibuprofen Tab 800mg	$78.05	$29.69
	Total	$223.63	$69.05

Requestor's Position

"On 01/09/2024, Memorial Wellness Pharmacy spoke with adjuster Reuben (Ref# 16199006), who confirmed that this bill was received by the carrier in July 2023 but that the claim was denied because prescription card must be used for payment to be processed. Memorial Wellness Pharmacy does not contract with the alternate vendor; therefore, payment should be processed by the direct carrier. This bill has been audited in error. This delay in payment should be reconsidered with interest applied."

Amount in Dispute: $223.63

Respondent's Position

The Austin carrier representative for Great Divide Insurance is Burns Anderson Jury & Brenner LP. Burns Anderson Jury & Brenner LP was notified of this medical fee dispute on April 23, 2024. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

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 (TAC) §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.

Denial Reasons

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

- 91 – Dispensing fee adjustment
- A1, XA1 – Claim/Service denied.
- G01 – This item was priced as a generic prescribed drug.
- G10 – This service was priced at submitted charges.
- Note: Claim service denied – per the claims adjuster the claimant must use prescription card supplied to them. The carrier does not reimburse Rx directly to the pharmacy/dispensing company.

Issues

1. Is insurance carrier's denial supported?

2. What rule is applicable to reimbursement?

3. Is requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of medications dispensed in July of 2023. The insurance carrier's explanation of benefits included a note stating the carrier does not reimburse Rx directly to the pharmacy/dispensing company. This denial is not supported by a position statement from the respondent or applicable DWC rules or fee guidelines. This denial will not be considered in this review. The disputed charges will be reviewed per applicable fee guidelines.

2. DWC Rule 28 Texas Administrative Code §134.503 (c)(1)(A)(B) states in pertinent part (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

   (1) 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:

   (A) 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
Acetaminophen	49483069901	G	0.102	90	$15.48	$72.18	$15.48
Gabapentin	71093016105	G	0.53	30	$23.88	$73.40	$23.88
Ibuprofen	59651036205	G	0.68	30	$29.69	$78.05	$29.69
						$223.63	$69.05

3. The total reimbursement is $69.05. 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 requester has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Great Divide Insurance Co must remit to Memorial Wellness Pharmacy $69.05 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 17, 2024
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.