



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Injured Workers Pharmacy LLC

**Respondent Name**

ACIG Insurance Co

**MFDR Tracking Number**

M4-25-0259-01

**Carrier's Austin Representative**

Box Number 47

**DWC Date Received**

October 2, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 27, 2023	70512010610 Diclofenac Sodium 1% Gel	\$64.69	\$0.00
December 26, 2023	70512010610 Diclofenac Sodium 1% Gel	\$64.69	\$0.00
March 18, 2024	70512010610 Diclofenac Sodium 1% Gel	\$64.69	\$0.00
April 11, 2024	70512010610 Diclofenac Sodium 1% Gel	\$64.69	\$0.00
May 13, 2024	70512010610 Diclofenac Sodium 1% Gel	\$64.69	\$0.00
June 6, 2024	70512010610 Diclofenac Sodium 1% Gel	\$64.69	\$0.00
July 5, 2024	70512010610 Diclofenac Sodium 1% Gel	\$64.69	\$0.00
July 30, 2024	70512010610 Diclofenac Sodium 1% Gel	\$820.00	\$0.00
<b>Total</b>		<b>\$1,272.83</b>	<b>\$0.00</b>

## Requestor's Position

"The attached bills were not paid in accordance with the Texas fee schedule. We requested further explanation as well as EOBs from the prescriber, but we didn't receive all the EOBs requested and the carrier has not issued payment in full as requested in our [sic] appeal letters. There will be missing EOBs as carrier has not provided them, please review and advise if there is anything we can do on our side to ensure our bills are paid in accordance with the Texas fee schedule."

**Amount in Dispute:** \$1,272.83

## Respondent's Position

"The Carrier was not given the retail price for the cost of the Diclofenac Sodium; therefore, Metadata has developed a methodology to determine an allowance, which is the amount that was paid. Carrier has also processed reconsideration EOB for date of service July 30, 2024 to correct the recommended allowance so that the reimbursement amount is consistent with the prior reimbursement amounts for the same medication."

**Response submitted by:** Burns Anderson Jury & Brenner, L.L.P.

## 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 \(TAC\) §133.307](#) 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 §134.500](#) defines closed formulary.

### Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- D2 (P12) – The charge for the over-the-counter medication exceeds the retail price.
- W3 – Additional payment was made on appeal/reconsideration.
- TE13 – level 1 appeal means a request for reconsideration under 133.250.

## Issues

1. Is the respondent's position supported?

## Findings

1. Injured Workers Pharmacy LLC is requesting additional reimbursement for the disputed prescription, Diclofenac Sodium 1% Gel.

The insurance carrier reduced the amount billed as the medication exceeds the retail price.

DWC Rule 28 TAC §134.503 (1) states, "This section applies to the reimbursement of prescription drugs and nonprescription drugs or over-the counter medications as those terms are defined in §134.500 of the title (relating to Definitions) for outpatient use in the Texas workers' compensation system."

DWC Rule 28 TAC §134.500 (3) states, "Closed formulary—All available Food and Drug Administration (FDA) approved prescription and nonprescription drugs prescribed and dispensed for outpatient use."

DWC Rule 28 TAC §134.503 states, "(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:"

Based on the rules shown above the disputed medication (Diclofenac Sodium 1% gel) was found to be on the closed formulary described above and subject to requirements of applicable DWC fee guidelines.

The respondent supported payment of the disputed services as follows.

- Date of service November 27, 2023. Payment \$242.77, payment ID: 3009570480TMC
- Date of service December 26, 2023. Payment \$242.77, payment ID: 3009570417TMC
- Date of service March 18, 2024. Payment \$242.77, payment ID: 3009628536TMC
- Date of service April 11, 2024. Payment \$242.77, payment ID: 3009666675TMC
- Date of service May 13, 2024. Payment \$242.77, payment ID: 3009705445TMC
- Date of service June 6, 2024. Payment \$242.77, payment ID: 3009732833TMC
- Date of service July 5, 2024. Payment \$242.77, payment ID: 3009775807TMC
- Date of service July 30, 2024. Payment \$633.92 in response to reconsideration dated October 14, 2024.

Injured Workers Pharmacy LLC submitted insufficient documentation to support its request for additional payment. In their response, Injured Workers Pharmacy LLC did not demonstrate how it arrived at the requested amount or whether that amount is consistent with the methodology under 28 TAC §134.503 (c). No additional payment is recommended.

### **Conclusion**

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### **Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

November 7, 2024  
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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).