



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

Injured Workers Pharmacy, LLC

**Respondent Name**

ACIG Insurance Co.

**MFDR Tracking Number**

M4-25-1969-01

**Carrier's Austin Representative**

Box Number 47

**DWC Date Received**

April 23, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 23, 2024	70512010610	\$186.08	\$186.08
September 17, 2024	70512010610	\$186.08	\$186.08
October 11, 2024	70512010610	\$64.69	\$64.69
January 3, 2025	70512010610	\$64.69	\$64.69
<b>Total</b>		<b>\$501.54</b>	<b>\$501.54</b>

### Requester's Position

"Carrier did not process at the Texas Fee Schedule for the medication DICLOFENAC SODIUM 1% GEL (cost 2.4277) ...

"The medication DICLOFENAC SODIUM 1% GEL was not processed according to the Texas Fee Schedule is AWP \* 1.25 = \$4.00.

"FOR QY of 100: AWP of 242.77 \* 1.25 + \$4.00 = 307.45. IWP only received a payment of \$242.77. For QY of 300 AWP of 728.31 \* 1.25 + \$4.00 = 914.39. IWP only received a payment of \$728.31"

"Tristar is only paying the AWP not the full TX fee schedule"

**Amount in Dispute: \$501.54**

## Respondent's Position

"As reflected in the EOBs, ACIG Insurance Co. properly reimbursed Injured Workers Pharmacy in accordance with the Texas Workers' Compensation Act and Division Rules.

"Diclofenac Sodium is an over the counter/non-prescription drug, whose reimbursement rate is determined by Division Rule 134.503(d) ...

"The Carrier was not given the retail price for the cost of the Diclofenac Sodium; therefore, Metadata [sic] has developed a methodology to determine an allowance, which is the amount that was paid."

**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 \(TLC\) §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.

### Denial Reasons

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

- Note-0001 – "The NDC code billed is for an Over the Counter (OTC) drug and as such does not warrant a dispensing fee."
- P12:D2 – Workers' compensation jurisdictional fee schedule adjustment.
- W3:@G – The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.
- @G(W3) – No additional reimbursement allowed after review of appeal/reconsideration.
- D2(P12) – The charge for the over-the-counter medication exceeds the retail price.

### Issues

1. Are the insurance carrier's reduction reasons supported?
2. Is Injured Workers Pharmacy entitled to additional reimbursement for the drugs in question?

## Findings

1. Injured Workers Pharmacy is seeking additional reimbursement for Diclofenac Sodium, NDC 70512010610, dispensed August 23, 2024, through January 3, 2025. The insurance carrier reduced payment stating that "the charge for the over-the-counter medication exceeds the retail price," and "The NDC code billed is for an Over the Counter (OTC) drug and as such does not warrant a dispensing fee."

Per 28 TAC §134.503(d), "Reimbursement for nonprescription drugs or over-the-counter medications must be the retail price of the lowest package quantity reasonably available that will fill the prescription." Based on the documentation provided by the insurance carrier, DWC found no evidence that the drug in question was an over-the-counter medication, nor did it provide a retail price which could be applied in this case to support its reduction.

In its position statement the insurance carrier referenced 28 TAC §134.503(e) to support its reduction amount. This subsection states, in relevant part, "Except as provided by subsection (f) of this section, **if an amount cannot be determined under subsections (c)(1) or (d)** of this section, reimbursement must be an amount that is consistent with the criteria listed in Labor Code §408.028(f), including providing for reimbursement rates that are fair and reasonable." [emphasis added] Based on the drug as billed, DWC finds that an amount can be determined under subsection (c)(1). Therefore, the procedures in subsection (e) do not apply.

DWC concludes that the insurance carrier's reduction reasons are not supported.

2. Because the insurance carrier failed to support its reduction of payment, DWC will review the disputed drugs for additional reimbursement.

The reimbursement considered in this dispute is calculated according to 28 TAC §134.503(c)(1)(A), with relevant formula for generic drugs:  $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.25) + \$4.00 \text{ dispensing fee per prescription} = \text{reimbursement amount}$ .

- Diclofenac Sodium 1% Gel:  $(2.42770 \times 300 \times 1.25) + \$4.00 = \$914.39 \times 2 \text{ dates of service} = \$1,828.78$
- Diclofenac Sodium 1% Gel:  $(2.42770 \times 100 \times 1.25) + \$4.00 = \$307.46 \times 2 \text{ dates of service} = \$614.92$

The total allowable amount is \$2,443.70. The submitted explanations of benefits indicate the insurance carrier paid \$1,942.16. DWC finds that Injured Workers Pharmacy is entitled to an addition reimbursement of \$501.54. This amount is recommended.

## 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 requester has established that additional reimbursement of \$501.54 is due.

## 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 ACIG Insurance Co. must remit to Injured Workers Pharmacy \$501.54 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

### Authorized Signature

\_\_\_\_\_  
Signature

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

July 25, 2025  
\_\_\_\_\_  
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 three 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 tres o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).