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
Injured Workers Pharmacy

Respondent Name
City of Houston

MFDR Tracking Number
M4-25-2612-01

Insurance Carrier's Austin Representative
BOX 29 Pappas & Suchma PC

DWC Date Received
June 20, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
November 21, 2024	NDC 70512010610	$1,214.81	$4.00
December 23, 2024	NDC 70512010610	$1,518.27	$0.00
January 16, 2025	NDC 70512010610	$1,518.27	$1,004.00
	Total	$4,251.35	$1,008.00

Requester's Position

"The attached bills have been severely underpaid by the insurer/PBM. We have requested EOBs as well as submitted appeals..."

Amount In Dispute: $4,251.35

Respondent's Position

"Following a thorough review of the claim history and the accompanying documentation, additional payment is not recommended. Dates of service previously processed for payment above fee guidelines."

Response Submitted By: Injury Management Organization, Inc.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code Section 413.031 and other applicable laws and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section 133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC Section 134.503 sets out the fee guidelines for services provided by a pharmacy.

Adjustment Reasons

The insurance carrier reduced payment for the disputed services with the following reasons:

1. 91 – Dispensing fee adjustment.
2. P12 – Workers' compensation jurisdictional fee schedule adjustment.
3. Note: "The billed amount for drug or supply exceeds Medispan allowance."
4. Note: "The NDC code billed is for an Over the Counter (OTC) drug and as such does not warrant a dispensing fee."
5. Note: "Charge exceeds Fee Schedule allowance"

Issues

1. What is DWC considering in this medical fee dispute?
2. Is the insurance carrier's reduction supported?
3. Is the requester entitled to additional reimbursement?

Findings

1. Injured Workers Pharmacy is seeking additional reimbursement for Diclofenac Sodium, NDC 70512010610, dispensed November 21, 2024, through January 16, 2025. The insurance carrier made partial payments for the drugs. These are the services considered in this dispute.

2. The insurance carrier reduced payment, in part, stating that "The NDC code billed is for an Over the Counter (OTC) drug and as such does not warrant a dispensing fee."

   Per 28 TAC Section 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."

   28 TAC Sections 133.307(d)(2)(E)(iv) and (v) state,

   (iv) a discussion regarding how the submitted documentation supports the respondent's

position for each disputed fee issues;

(v) documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable reimbursement in accordance with Labor Code §413.011 and §134.1 or §134.503 of this title if the dispute involves health care for which the division has not established a MAR or reimbursement rate, as applicable.

DWC found no evidence in the submitted documentation that the drug in question was an over-the-counter medication. The insurance carrier also failed to provide a retail price which could be applied in this case to demonstrate and justify that its reduction was in accordance with 28 TAC Section 134.503(d).

The insurance carrier also stated, "The billed amount for drug or supply exceeds Medispan allowance."

28 TAC Section 134.503(c)(1), bases the calculation for reimbursement on "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."

The insurance carrier provided no documentation to support its calculation for the reimbursement made.

3. Because the insurance carrier failed to support its payment calculation, reimbursement will be evaluated in accordance with 28 TAC Section 134.503(c)(1)(A), with the relevant formula for generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount.

Date of Service	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and	Paid Amt	Amount Due
11/21/2024	70512010610	G	$2.42770	400	$1,217.85	$1,217.85	$1,217.85	$1,213.85	$4.00
12/23/2024	70512010610	G	$2.42770	500	$1,521.31	$1,521.31	$1,521.31	$1,521.31	$0.00
1/16/2025	70512010610	G	$2.42770	500	$1,521.31	$1,521.31	$1,521.31	$517.31	$1,004.00
						Total	**$4,260.47**	**$3,252.47**	**$1,008.00**

The total allowable reimbursement is $4,260.47. Per explanations of benefits provided, the insurance carrier paid $3,252.47. An additional $1,008.00 is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence requester and the respondent presented 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 Sections 413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that City of Houston must remit to Injured Workers Pharmacy $1,008.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section 134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 25, 2026 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC Section 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 800-252-7031, option three 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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section 141.1(d).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.