



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Injured Workers Pharmacy

Respondent Name

ACIG Insurance Co

MFDR Tracking Number

M4-26-0298-01

Insurance Carrier's Austin Representative

BOX 47 Burns Anderson Jury Brenner & Donovan

DWC Date Received

September 30, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
May 30, 2025	NDC 70512010610	\$186.08	\$186.08
Total		\$186.08	\$186.08

Requester's Position

"The DOS in question is 5/30/25 for the medication DICLOFENAC SODIUM 1% GEL NDC 70512010610. IWP billed TX fee schedule for \$914.39, but only received a payment of 728.31

"Mark up info: 300.00(QY) Multiply 2.4277(COST Multiply 1.25(GENRIC) Add 4.00(DISPENSING FEE) = \$914.39"

Amount In Dispute: \$186.08

Respondent's Position

"ACIG would show the amount in dispute was denied in accordance with the DWC Medical Fee Guidelines. The Requester calculated and sought reimbursement based solely on DWC Rule 134.503(c)(1)(A). However, DICLOFENAC SODIUM 1% GEL available over-the-counter; therefore, DWC Rule 134.503(d) applies, and reimbursement is limited to the retail price. As reflected in the

attached EOBs, Carrier calculated reimbursement in accordance with this provision, and advised the Requestor of same.”

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 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. P12 – Workers’ compensation jurisdictional fee schedule adjustment.
2. D2 – The charge for the over-the-counter medication exceeds the retail price.

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. The requester is seeking additional reimbursement for Diclofenac Sodium, NDC 70512010610, dispensed May 30, 2025. The insurance carrier reduced payment citing fee guidelines and stating, “The charge for the over-the-counter medication exceeds the retail price.” This is the service considered in this dispute.
2. In its position statement, the insurance carrier argued that “DICLOFENAC SODIUM 1% GEL available over-the-counter; therefore, DWC Rule 134.503(d) applies, and reimbursement is limited to the retail price. ”

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).

DWC finds that the insurance carrier's reason for reduction of payment for the drug in question is not supported.

3. Because the insurance carrier's reduction reason is not supported, DWC will review the reimbursement based on applicable fee guidelines.

28 TAC Section 134.503(e) 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 outlined in subsection (e) do not apply.

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

$$\text{Diclofenac Sodium: } (2.4277 \times 300 \times 1.25) + \$4.00 = \$914.39$$

The total allowable reimbursement for the drug considered in this dispute is \$914.39. The insurance carrier paid \$728.31. An additional reimbursement of \$186.08 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 ACIG Insurance Co

must remit to Injured Workers Pharmacy \$186.08 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 20, 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 electrónico CompConnection@tdi.texas.gov.