



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Injured Workers Pharmacy, LLC

Respondent Name

Zurich American Insurance Co.

MFDR Tracking Number

M4-26-0599-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

October 30, 2025

Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|------------------|-------------------|-------------------|------------|
| May 1, 2025 | 70512010610 | \$64.69 | \$64.69 |

Requester's Position

"There is no evidence that the drug in question is an over-the-counter medication, nor was there a retail price which could be applied to support the reduction."

Amount in Dispute: \$64.69

Respondent's Position

"The pharmacy vendor OPTUM paid the bill according to the fee schedule. No additional monies are owed."

Response Submitted by: Flahive, Ogden & Latson

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:

- D2(P12) – The charge for the over-the-counter medication exceeds the retail price.
- 60 (B13) – The provider has billed for the exact services on a previous bill.
- QG – (W3) – No additional reimbursement allowed after review of appeal/reconsideration.

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 May 1, 2025. The insurance carrier reduced payment stating that "the charge for the over-the-counter medication exceeds the retail price."

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.

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 per unit) x (number of units) x 1.25) + \$4.00 dispensing fee per prescription = reimbursement amount.

- Diclofenac Sodium 1% Gel: (2.42770 x 100 x 1.25) + \$4.00 = \$307.46

The total allowable amount is \$307.46. The submitted explanations of benefits indicate the insurance carrier paid \$242.77. DWC finds that Injured Workers Pharmacy is entitled to an addition reimbursement of \$64.69. 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 \$64.69 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 Zurich American Insurance Co. must remit to Injured Workers Pharmacy \$64.69 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

December 4, 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. 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.

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.