



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

EZ Scripts LLC

Respondent Name

Norguard Insurance Company

MFDR Tracking Number

M4-25-0454-01

Carrier's Austin Representative

Box Number 12

Date Received

October 25, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 14, 2022	NDC # 33342-0156-11 / Celecoxib	\$177.00	\$0.00
September 14, 2022	NDC # 50742-0226-15 / Tizanidine HCL	\$583.20	\$0.00
Total		\$760.20	\$0.00

Requestor's Position

"Tizanidine HCL 6 MG and Celecoxib 100 MG were 'Y' drugs on the ODG formulary in September 2022. The medications did not require preauthorization. They were denied with code U00 'there was no UR procedure/treatment request received.'"

Amount in Dispute: \$760.20

Respondent's Position

The Austin carrier representative for Norguard Insurance Company is Shanley Price LLP. Shanley Price LLC was notified of this medical fee dispute on October 29, 2024. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

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](#)) [§133.305](#) sets out the procedures for resolving medical disputes.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.

Denial Reasons

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

- 18 – Exact duplicate service.
- 224 – Duplicate charge.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 790 - This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
- 91 - Dispensing fee adjustment.
- 95 - Plan procedures not followed.
- G01 - This item was priced as a generic prescribed drug.
- P12 - Workers' compensation jurisdictional fee schedule adjustment.
- PS2 - NDC charge(s) have been denied and no payment is recommended per Script advisor clinical and formulary-based review.
- U00 - There was no UR procedure/treatment request received.

Issues

Has the requestor waived their right to medical fee dispute resolution?

Findings

The requestor seeks payment in the amount of \$760.20, for prescription services provided on September 14, 2022.

28 TAC §133.307 (c) (1) states in the pertinent part, "Timeliness. A requestor must timely file the request with the division or waive the right to MFDR. The division will deem a request to be filed on the date the division receives the request. A decision by the division that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section."

The prescriptions in question were dispensed on September 14, 2022. The medical fee dispute

was received by the Division on October 25, 2024. This date is more than a year following the in-
question date(s) of service.

28 TAC §133.307 (c) (1) (A) states, "A request for MFDR that does not involve issues identified in
subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of
service in dispute."

A review of the submitted documentation finds that the disputed service(s) does not involve
issues identified in 28 TAC §133.307 (c) (1) (B). The Division concludes that the requestor has
failed to timely file this dispute with the Division; consequently, the requestor has waived the
right to medical fee dispute resolution.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor
and the respondent at the time of adjudication. Though all evidence may not have been
discussed, it was considered.

The Division finds the requestor has not established that reimbursement is due.

Order

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

Authorized Signature

_____	_____	January 23, 2025
Signature	Medical Fee Dispute Resolution Officer	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. The
Division must receive the request within **20 days** of when you receive this decision. You may fax,
mail, or personally deliver your request to the Division using the contact information on the form
or the field office handling the claim. If you have questions about the DWC Form-045M, call
CompConnection at 1-800-252-7031, option 3 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 the Division. **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.