



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

EZ Scripts LLC

**Respondent Name**

XL Insurance America Inc

**MFDR Tracking Number**

M4-25-1510-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

March 9, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 3, 2024	NDC # 29300-0125-10	\$367.38	\$367.37
June 28, 2024	NDC # 29300-0125-10	\$367.38	\$367.37
<b>Total</b>		<b>\$734.76</b>	<b>\$734.74</b>

### Requestor's Position

"MyMatrixx and Broadspire bill review denied the Meloxicam 15mg tab filled on 05/03/2024 & 06/28/2024 for 'Not a Work-Related injury/illness'. This was a Y drug on the ODG drug formulary in 2024."

**Amount in Dispute:** \$734.76

### Respondent's Position

The Austin carrier representative for XL Insurance America Inc is Flahive Ogden & Latson. Flahive Ogden & Latson was notified of this medical fee dispute on March 19, 2025. 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.
3. [28 TAC §134.503](#) sets out the fee guidelines for pharmacy.

### **Denial Reasons**

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

- P2 – Not a work-related injury/illness and thus not the liability of the workers' compensation carrier.

### **Issues**

1. Did the insurance carrier submit a copy of a PLN in support of the denial reason?
2. Is the requester entitled to additional reimbursement?

### **Findings**

1. The requestor is seeking reimbursement of Meloxicam dispensed on May 3, 2024, and June 28, 2024. The insurance carrier denied the disputed prescriptions with denial code P2 – Not a work-related injury/illness and thus not the liability of the workers' compensation carrier.

28 TAC §133.307(d)(2)(H), "Responses. Responses to a request for MFDR must be legible and submitted to the division and to the requestor in the form and manner prescribed by the division... (H) If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier must attach any related Plain Language Notice in accordance with §124.2 of this title (concerning Insurance Carrier Reporting and Notification Requirements)."

The respondent did not submit a response to the Medical Fee Dispute Resolution (MFDR) request. Upon review of the documentation, it was found that the carrier failed to provide evidence to the Division confirming that a Plain Language Notice (PLN) was filed concerning the disputed conditions, as required by §133.307(d)(2)(H).

Additionally, there is no evidence to show that the Plain Language Notice (PLN) was ever presented to the requestor or that the requestor was informed of the PLN prior to the filing date of the MFDR request with the Division of Workers' Compensation (DWC). Therefore, the DWC finds that the denial based on the extent of injury was not timely presented to the requestor.

Since the disputed service does not involve an unresolved extent of injury issue, this dispute qualifies for adjudication under 28 TAC §133.307. Accordingly, this matter will be resolved in accordance with the applicable rules and guidelines.

2. The requester billed medication Meloxicam on May 3, 2024, and June 28, 2024. Because the insurance carrier's denial reason is not supported, the requester is entitled to reimbursement.

28 TAC §134.503 (c) states the insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of 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:

- Generic drugs: ((AWP per unit) x (number of units) x 1.25) + \$4.00 dispensing fee per prescription = reimbursement amount;

Date	Drug	NDC	Generic(G) Brand(B)	Price / Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed Amt
05/03/24	Meloxicam	29300012510	G	4.84500	60	\$367.37	\$367.38	\$367.37
06/28/24	Meloxicam	29300012510	G	4.84500	60	\$367.37	\$367.38	\$367.37
<b>TOTAL</b>						\$734.74	\$734.76	\$734.74

The total reimbursement is \$734.74. This amount is recommended.

**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.

DWC finds the requester is entitled to reimbursement in the amount of \$734.74.

**Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that respondent must remit to the requestor \$734.74 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

June 10, 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, call CompConnection at 1-800-252-7031, option 3 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 3 o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).