



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

EZ Scripts

**Respondent Name**

Fort Bend County

**MFDR Tracking Number**

M4-25-1626-01

March 20, 2025

**Carrier's Austin Representative**

Box Number 29

**DWC Date Received**

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 2, 2024	29300-0413-05	\$65.50	\$65.50
August 2, 2024	67877-0321-05	\$94.56	\$94.55
		\$160.06	\$160.05

### Requester's Position

"Enclosed are the outstanding pharmacy bill from EZ Scripts, which were submitted to Davies Claims Solutions in a timely manner after each prescription was filled. Davies Claims Solutions & Genex bill review processed the CYCLOBENZAPRINE HCL 5mg Y Ibuprofen 800mg Tab filled for DOS 08/02/2024; however, the bill was never paid. This was a Y drug on the ODG drug formulary in January 2023."

**Amount in Dispute:** \$160.06

### Respondent's Position

The Austin carrier representative for Fort Bend County is Dean G Pappas Law Firm. The representative was notified of this medical fee dispute on April 10, 2025.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available

information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

## 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 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.503](#) sets out the fee guidelines for pharmacy services.

### Denial Reasons

- Neither party submitted evidence of adjudication of the disputed service.

### Issues

1. What rule is applicable to reimbursement?
2. Is the requester entitled to reimbursement?

### Findings

1. The requester seeks reimbursement of the following medications for date of service August 2, 2024. The insurance carrier did not respond to this request for MFDR.
  - Cyclobenzaprine HCL 5mg, quantity 30, billed amount \$65.50
  - Ibuprofen 800mg, quantity 90, billed amount \$94.56

DWC Rule 28 Texas Administrative Code §134.503 (c)(1)(A)(B) states in pertinent part (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

(1) 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:

(A) Generic drugs:  $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \$4.00$  dispensing fee per prescription = reimbursement amount;

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Cyclobenzaprine	29300041305	G	1.64	30	\$65.52	\$65.50	\$65.50
Ibuprofen	67877032105	G	0.80	90	\$94.55	\$94.56	\$94.55

2. The total reimbursement is \$160.05, 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 is due.

**Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that Fort Bend County must remit to EZ Scripts \$160.05 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130

**Authorized Signature**

		July 9, 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](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, please 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 electronico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).