



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

EZ Scripts LLC

Respondent Name

Metropolitan Transit Authority of Harris County

MFDR Tracking Number

M4-25-1649-01

Carrier's Austin Representative

Rep Box 19

DWC Date Received

March 24, 2025

Summary of Findings

Dates of Service	Disputed Services			Amount in Dispute	Amount Due
September 20, 2024	NDC #	65862-0969-01	Eszopiclone	\$441.81	\$441.80
October 17, 2024	NDC #	70954-0020-10	Prazosin HCl	\$53.58	\$53.58
December 12, 2024	NDC #	65862-0969-01	Eszopiclone	\$441.81	\$441.69
Total				\$937.20	\$937.07

Requestor's Position

"Prazosin HCL 2 MG filled on 10/17/2024, and Eszopiclone 3 MG filled on 12/12/2024 were denied with the reason "precertification/authorization/notification absent." These were a Y drugs on the ODG formulary when the medications were filled and did not require preauthorization."

Amount in Dispute: \$937.20

Respondents' Position

"The pharmacy bills have been denied. The carrier's reasons are set out on its EOBs."

Received by: Flahive, Ogden & Latson

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 §133.305](#) sets out the general procedures for medical dispute resolution.
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.
4. 28 Texas Administrative Codes [§§134.530](#) and [134.540](#) sets out the closed formulary requirements, effective January 17, 2011, 35 TexReg 11344.

Denial Reasons

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

- 197 - Precertification/authorization/notification absent.
- 45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. usage: this adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual
- 91 - Dispensing fee adjustment.
- Note: NDC charge(s) have been denied, and no payment is recommended by Script advisor clinical and formulary-based review.
- P12 - Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Is insurance carrier's denial reason(s) supported?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement in the amount of \$937.20 for medication(s) dispensed on September 20, 2024, October 17, 2024, and December 12, 2024. The insurance carrier is denying reimbursement due to the denial reasons indicated above.

A review of the submitted documentation indicates that the insurance carrier denied the disputed drugs based on lack of preauthorization. Preauthorization is only required for:

- drugs identified with a status of "N" in the current edition of the ODG Appendix A
- any compound prescribed before July 1, 2018, that contains a drug identified with a status of "N" in the current edition of the ODG Appendix A
- any prescription drug created through compounding prescribed and dispensed on or after July 1, 2018; and
- any investigational or experimental drug.

The DWC finds that the drugs in question are identified with a status of "Y" in the applicable edition of the ODG, Appendix A. These drugs do not require preauthorization for this reason. The DWC concludes that the insurance carrier's denial of payment of the disputed drug based on lack of preauthorization is not supported.

Based on the documentation provided, DWC finds that the carrier failed to sufficiently support the denial for reimbursement. The requestor is therefore entitled to reimbursement for the medications in dispute.

2. 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;

DOS	Drug	NDC	Generic (G) Brand (B)	Price/Unit	Units Billed	AWP	Billed Amt	Lesser of AWP and Billed Amt
9/20/2024	Eszopiclone	65862-0969-01	G	11.67470	30	\$441.80	\$441.81	\$441.80
10/17/2024	Prazosin HCl	70954-0020-10	G	1.32240	30	\$53.59	\$53.58	\$53.58
12/12/2024	Eszopiclone	65862-0969-01	G	11.67470	30	\$441.80	\$441.81	\$441.69*
TOTAL						\$937.19	\$937.20	\$937.07

*A review of the medical bill for Eszopiclone dispensed on December 12, 2024, finds that the insurance carrier issued a partial payment in the amount of \$0.11, reimbursement in the amount of \$441.80 - \$.011 = MAR amount of \$441.69, therefore this amount is recommended.

The total reimbursement is \$937.07. 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 has established that reimbursement of \$937.07 is due.

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 the respondent must remit to the requestor \$937.07 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	April 17, 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. 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.

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.