



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

EZ Scripts LLC

Respondent Name

Arch Insurance Co

MFDR Tracking Number

M4-25-1672-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

March 26, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 21, 2024	72888-0080-05	\$45.45	\$0.00

Requester's Position

"Tramadol was an N drug on the ODG formulary at the time the medication was filled. EZ Scripts submitted a preauthorization request on 08/13/2024. Sedgwick UR approved the medication on 08/15/2024 with review number 5698336."

Supplemental response August 12, 2025

"We still have not received the additional \$45.45."

Amount in Dispute: \$45.45

Respondent's Position

"The carrier is reprocessing the provider's pharmacy bill. We will supplement this response once the EOB has been issued."

Supplemental response from Sedgwick July 24, 2025

"On 7/8/2025 I advised that payment should be made, however, it has not shown up in juris to approve."

Response submitted 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 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §137.100](#) sets out the treatment guidelines.
3. [28 TAC §19.2003](#) sets out requirements of utilization review.
4. [28 TAC §19.2015](#) sets of the guideless of retrospective review.
5. [28 TAC §134.530](#) sets out the benefit guidelines for pharmaceutical services.
6. [28 TAC §134.503](#) sets out the fee guidelines for pharmacy services.

Denial Reasons

- 60 – (B13) – The provider has billed for the exact services on a previous bill.
- 9D – (P12) – The charge for the Closed Formulary Drug requires Prior Authorization as defined within Texas Administrative Code Chapter 134. Section 134.530 and 134.540. If Prior Authorization was obtained, please resubmit with a copy of the required information.
- ZR(P12) – The provider or a different provider has billed for the exact service on a previous bill where no allowance was originally recommended.
- HE70 – Product/Service not covered.

Issues

- 1. Was prior authorization required?
- 2. Is the requester entitled to reimbursement?

Findings

- 1. The requester seeks reimbursement of the medication Tramadol HCL 50mg (40) for date of service August 21, 2024. The insurance carrier denied for lack of prior authorization and not covered.

DWC Rule 134.530 (b)(1) states, "Preauthorization is only required for: (A) drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary..."

Review of the applicable Appendix A for August 2024 found Tramadol HCL is listed as a N drug. Prior authorization was required. The requester includes the statement, "Sedgwick UR approved the medication on 08/15/2024 with review number 5098336." Insufficient evidence was found to support the approval of the disputed medication.

- 2. The DWC finds that the requester is not entitled to reimbursement in the amount of \$45.45 for the medication Tramadol dispensed on August 21, 2024 as the submitted documentation does not support the services were prior authorized as required by rule.

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 not established that reimbursement is due.

Order

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

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

August 15, 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 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.