TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
EZ Scripts

Respondent Name
SFM Mutual Insurance Co

MFDR Tracking Number
M4-25-2269-01

Carrier's Austin Representative
Box Number 48

DWC Date Received
May 19, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 7, 2024	68180-0122-01 Cephalexin 500mg	$19.48	$19.48
October 16, 2024	42806-0400-21 Methylprednisolone 4mg	$47.31	$47.30
		$66.79	$66.78

Requester's Position

"Enclosed are the outstanding pharmacy bills from EZ Scripts, which were submitted to Gallagher Bassett Services, Inc. in a timely manner after each prescription was filled. Gallagher Bassett bill review denied the Cephalexin 500mg filled on 10/07/2024 & Methylprednisolone 4mg filled on 10/16/2024 for a lack of preauthorization. These were Y drugs on the ODG drug formulary in October 2024. All other dates of services that included medications were paid in full."

Amount in Dispute: $66.79

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: We have escalated the bills in question for manual review to determine if additional monies are owed."

Response submitted by: Gallagher Bassett

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 §133.240 sets out the requirements of medical payments and denials.
3. 28 TAC Chapter 19 Subchapter U sets out utilization reviews for health care provided under Workers' Compensation Insurance Coverage.
4. 28 TAC §134.503 sets out the fee guidelines for pharmacy services.
5. 28 TAC §134.530 sets out requirements of prior authorization

Denial Reasons

- 90438/197 – Payment denied/reduced for absence of precertification/authorization
- 5725 – First Script has denied the line for Utilization.
- 00663 – Reimbursement has been calculated based on the state guidelines.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Did the insurance carrier support the correct administrative process followed prior to denial for utilization?
2. Is the insurance carrier's denial for lack of prior authorization supported?
3. What rule is applicable to reimbursement?
4. Is the requester entitled to reimbursement?

Findings

1. The insurance carrier denied the disputed charges as, "First Script has denied the line for Utilization."

   DWC Rule 28 Texas Administrative Code §133.240 (q) states, in relevant part, "When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title ..."

Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title …, including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor ..."

Submitted documentation does not support that the insurance carrier followed the appropriate procedures for a retrospective review denial of the disputed services outlined in §19.2003 (b)(31) or §133.240 (q). This denial will not be considered in this review.

2. The requester seeks reimbursement of medications dispensed October of 2024. The insurance carrier denied the claim for lack of prior authorization. DWC Rule §134.530 (b) states, "Preauthorization for claims subject to the division's closed formulary.

   (1) 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, and any updates;

   Review of the applicable Appendix A found the medications in dispute; both have a status of "Y" indicator. Prior authorization was not required. The disputed medication will be reviewed by applicable fee guideline.

3. 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: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

      (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $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
Cephalexin	68180012201	G	1.376	9	$19.48	$19.48	$19.48
Methylprednisolone	42806040021	G	1.649	21	$47.30	$47.31	$47.30

4. The total reimbursement is $66.78; 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 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 SFM Mutual Insurance Co must remit to EZ Scripts $66.78 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130

Authorized Signature

		July 31, 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, 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 electronico CompConnection@tdi.texas.gov.