



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

EZ Scripts

**Respondent Name**

Sentry Casualty Co

**MFDR Tracking Number**

M4-25-3078-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

July 25, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 3, 2024	72888-0080-05 Tramadol HCL 50 mg	\$97.26	\$97.26
December 3, 2024	60505-0252-02 Tizanidine HCL 4mg	\$113.88	\$113.88
January 6, 2025	60505-0252-02 Tizanidine HCL mg	\$113.88	\$113.88
January 14, 2025	72888-0080-05 Tramadol HCL 50 mg	\$97.26	\$97.26
February 5, 2025	55111-0180-10 Tizanidine HCL	\$113.88	\$113.88
March 7, 2025	55111-0180-10 Tizanidine HCL	\$113.88	\$113.88
April 4, 2025	55111-0180-10 Tizanidine HCL	\$113.88	\$113.88
May 14, 2025	55111-0180-10 Tizanidine HCL	\$113.88	\$113.88
May 22, 2025	00406-0484-01 Acetaminophen/ Codeine	\$164.54	\$164.50
		<b>\$1,042.34</b>	<b>\$1,042.30</b>

## Requester's Position

"Tramadol filled on 12/03/2024 was denied with the code "prior Authorization required to process the bill." The medication was preauthorized and approved on 12/02/2024 with review number 6705270. The Tizanidine and Acetaminophen Codeine filled on the remaining dates of service were denied with the code "Denied – Based on entitlement of benefits." Supporting medical records for each date of service are attached."

**Amount in Dispute:** \$1,042.34

## Respondent's Position

The Austin carrier representative for Sentry Casualty Co is Flahive, Ogden & Latson . The representative was notified of this medical fee dispute on July 28, 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.
3. [28 TAC §134.530](#) sets out the requirements of prior authorization.

### Denial Reasons

- HE75 – Prior Authorization required to process this bill.
- VPEB – Denied – Based on entitlement to benefits.
- N3 (B20) - A reduction was made because a different provider has billed for the exact services on a previous bill.
- ZR (P12) – The provider or a different provider has billed for the exact service on a previous bill where no allowance was originally recommended.
- VPUR – Denied for UR.
- 60 – (B13) – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- P12: ZR – Workers' compensation jurisdictional fee schedule adjustment.

## Issues

1. Is the insurance carrier's denial for entitlement to benefits supported?
2. Is the insurance carrier's denial for lack of authorization supported?
3. Did the respondent support payment of acetaminophen/codeine on DOS 5-22-2025.
4. What rule is applicable to reimbursement?
5. Is the requester entitled to reimbursement?

## Findings

1. The requester seeks reimbursement of medications dispensed in December of 2024 through May of 2025. The medications were denied for several reasons. The first one addressed in this review is the denial based on entitlement of benefits.

DWC Rule 28 TAC §133.307(d)(2)(H) requires that if the medical fee dispute involves liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with Rule §124.2 (relating to carrier reporting and notification requirements).

DWC Rule 28 TAC §124.2(h) requires notification to the division and claimant of any dispute of liability using plain language notices with language and content prescribed by the division. Such notices "shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim."

Review of the submitted information finds no copies, as required by Rule §133.307(d)(2)(H), of any PLN 1 notices issued in accordance with Rule §124.2.

The insurance carrier's denial reason is not supported.

Furthermore, because the respondent failed to meet the requirements of Rule §133.307(d)(2)(H) regarding notice of issues of liability, the respondent has waived the right to raise such issues during dispute resolution.

2. The next denial of the medications addressed is prior authorization required. DWC Rule §134.530 (b)(1)(A) states in pertinent part, Preauthorization is only required for: 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 at [appendixa.xlsx](#) found, Tramadol is considered a "N" drug. Prior authorization was required. Tizanidine is listed as "Y" drug, prior authorization is NOT required.

The documentation submitted with this request for MFDR contained.

- Review #6705270 from GENEX that recommended certification of 90 Tramadol 50mg between 11/25/2024 and 3/25/2025.
- Review #6760821 from GENEX that recommended certification of 90 Tramadol

50mg between 1/9/2025 and 5/9/2025.

Based on this review, the medication (Tramadol) was authorized on 12/3/2024. The insurance carrier's denial is not supported. The medication (Tramadol) was authorized on January 14, 2025. The insurance carrier's denial is not supported. The medication Tramadol was prior authorized, the medication Tizanidine did not require prior authorization. These medications will be reviewed per applicable fee guideline.

3. The insurance carrier denied the medication Acetaminophen/Codeine dispensed on May 22, 2025 as a duplicate. The insurance carrier did not respond to this request for MFDR. Insufficient evidence was found to support another adjudication of date of service May 22, 2025. This claim line will be reviewed per applicable fee guideline.
  
4. The service in dispute will be reviewed per the applicable fee guidelines. 28 TAC §134.503 (c) (1) (A)(B)(C) states in pertinent part, 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 or the billed amount.

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

(B) Brand-name drugs:  $((\text{AWP per unit}) \times (\text{number of units}) \times 1.09) + \$4.00$  dispensing fee per prescription = reimbursement amount;

The calculation of the total allowable amount is as follows:

Drug Name	NDC No.	Generic (G) Brand (B)	Price/Unit	AWP	Billed Amount	Lesser of AWP and Billed Amount
Tramadol	72888008005	G	0.829/90	\$97.27	\$97.26	\$97.26
Tizanidine	60505025202	G	1.465/60	\$113.89	\$113.88	\$113.88
Tizanidine	60505025202	G	1.465/60	\$113.89	\$113.88	\$113.88
Tramadol	72888008005	G	0.829/90	\$97.27	\$97.26	\$97.26
Tizanidine	60505025202	G	1.465/60	\$113.89	\$113.88	\$113.88
Tizanidine	60505025202	G	1.465/60	\$113.89	\$113.88	\$113.88
Tizanidine	60505025202	G	1.465/60	\$113.89	\$113.88	\$113.88
Tizanidine	60505025202	G	1.465/60	\$113.89	\$113.88	\$113.88

Acetaminophen/ Codeine	00406048401	G	1.426/90	\$164.50	\$164.54	\$164.50
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5. The DWC finds that the requester is entitled to reimbursement in the amount of \$1,042.30. 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 Sentry Casualty Co must remit to EZ Scripts \$1,042.30 plus applicable accrued interest within 30 days of receiving this order in accordance with [28 TAC §134.130](#).

**Authorized Signature**

_____	_____	October 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](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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).