



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

EZ Scripts

Respondent Name

WC Solutions

MFDR Tracking Number

M4-26-0142-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

September 16, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 20, 2024	72205-0012-90	\$952.04	\$0.00
November 20, 2024	29300-0125-10	\$185.69	\$0.00
	Total	\$1,137.73	\$0.00

Requestor's Position

"It has been confirmed by Dr. Burch's office that Dr. Gonzalez is the treating physician and Dr. Gonzalez sends the patient to Dr. Burch for medication management. They confirm that their bills are being paid. Out of 4 dates of services EZ Scripts submitted, just the 11/20/24 DOS was not paid.

Amount in Dispute: \$1,137.73

Respondent's Position

"We have reviewed the charge in dispute and determined no payment is due. Dr. Francis Burch was not the approved treating doctor or an approved referral doctor for this work related injury on the date these services were incurred."

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 §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [TLC §408.021](#) defines the entitlement to benefits.

Denial Reasons

Neither party submitted an explanation of benefits related to the disputed services.

Issues

1. Is the requester's position statement supported?

Findings

1. EZ Scripts is seeking reimbursement for prescription medications dispensed on date of service November 20, 2024. The insurance carrier responded to MFDR stating, "Dr. Francis Burch was not the approved doctor or an approved referral doctor for this work related injury on the date these services were incurred."

The requester states, "It has been confirmed by Dr. Burch's office that Dr. Gonzalez is the treating physician and Dr. Gonzalez sends the patient to Dr. Burch for medication Management."

TLC §408.021(c) states, "Except in an emergency, all health care must be approved or recommended by the employee's treating doctor."

No evidence was provided the service in question was an emergency or that the prescriber was the injured employee's treating doctor. Insufficient evidence found to support a referral was made to Dr. Burch for treatment.

The requester's position statement is not supported. No payment can be 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 not established that additional reimbursement is due.

Order

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

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	_____ October 8, 2025 Date
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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.