



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

EZ Script

Respondent Name

Mitsui Sumitomo Ins

MFDR Tracking Number

M4-26-0584-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

October 30, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
May 29, 2025	00406-0125-10	\$50.45	\$0.00
June 16, 2025	00406-0125-10	\$50.45	\$0.00
July 7, 2025	00406-0125-10	\$50.45	\$0.00
Total		\$151.35	\$0.00

Requester's Position

"Despite repeated attempts to resolve the issue directly with both CorVel and the carrier, no resolution or response was received."

Amount In Dispute: \$151.35

Respondent's Position

The Austin carrier representative for Mitsui Sumitomo Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on October 31, 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 Section [413.031](#) and other applicable laws and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section [133.307](#) sets out the procedures for resolving medical fee disputes
2. Labor Code Section [408.021](#) sets out the general provisions for entitlement to workers' compensation benefits.

Adjustment Reasons

- 185 – Denied, provider not eligible to perform svc billed.
- 184 – Prescribing HCP not eligible to prescribe the svc billed.

Issues

1. What is DWC considering in this medical fee dispute?
2. Is the insurance carrier's denial supported?

Findings

1. The requester is seeking payment of the oral medication Hydrocodone/Apap 10-325mg for dates of service in May, June and July of 2025. The insurance denied each medical bill stating the services were not prescribed by the injured workers treating physician and the provider was not eligible to perform the denied service.
2. 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.
DWC found no evidence that the prescriber obtained the approval or recommendation of the treating doctor.
Therefore, DWC finds that the denial of payment for these dates of service are supported.

Conclusion

The outcome of this medical fee dispute is based on the evidence requester and the respondent presented 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 Sections [413.031](#) and [413.019](#), DWC has determined the requester is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	January 29, 2026
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 Section [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 800-252-7031, option three 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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section [141.1\(d\)](#).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electrónico CompConnection@tdi.texas.gov.