TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

EZ Script

Respondent Name

Insurance Company of the West

MFDR Tracking Number

M4-26-1154-01

Insurance Carrier's Austin Representative

BOX 4 Law Office Of Ricky D Green

DWC Date Received

December 16, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
June 23, 2025	50228-0464-01	$30.20	$30.20
	Total	$30.20	$30.20

Requester's Position

Tristar and Mithell bill review partially paid the bill but at the OH fee schedule.

Amount In Dispute: $30.20

Respondent's Position

Medi Span AWP $1.23830 x 60 = $72.298 x 125.0% state mark up = $92.8725 + $4.00 dispensing fee = $96.87. Provider billed below AWP calculations.

Response Submitted By: ICW Group

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. 28 TAC Section 134.503 sets out the fee guidelines for services provided by a pharmacy.

Adjustment Reasons

- 350 – Bill has been identified as a request for reconsideration or appeal.
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guidelines.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What is DWC considering in this medical fee dispute?
2. What rule is applicable to reimbursement?
3. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking additional reimbursement of the medication Nabumetone dispensed on June 23, 2025. The insurance supports a payment of $66.65. The balance in dispute is $30.20.

2. 28 TAC Section 134.503(c)(1)(A)(B) states in pertinent part,

   (c) the insurance carrier must 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 or the billed amount.

   (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;

   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
Nabumetone	50228046501	G	1.238/60	$96.87	$96.85	$96.85

3. The DWC finds that the requester is entitled to reimbursement in the amount of $96.85. The insurance carrier supports a payment of $66.65. Additional reimbursement in the amount of $30.20 is recommended.

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 established that additional reimbursement is due.

Order

Under Texas Labor Code Sections 413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that Insurance Co of the West must remit to EZ Script $30.20 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section 134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 23, 2026 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 electronico CompConnection@tdi.texas.gov.