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 Scripts

Respondent Name

New Hampshire Insurance Company

MFDR Tracking Number

M4-26-1857-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

February 27, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
May 23, 2025	55111-0158-10	$159.70	$159.68
June 20, 2025	55111-0158-10	$159.70	$159.68
June 20, 2025	00406-0484-01	$111.02	$111.00
July 21, 2025	55111-0158-10	$159.70	$159.68
July 21, 2025	00406-0484-01	$111.02	$111.00
July 21, 2025	29300-0413-05	$127.00	$127.00
August 18, 2025	55111-0158-10	$159.70	$159.68
August 18, 2025	00406-0484-01	$111.02	$111.00
August 18, 2025	29300-0413-05	$127.00	$127.00
September 16, 2025	55111-0644-10	$159.70	$159.68

September 16, 2025	00406-0484-01	$111.02	$111.00
September 16, 2025	29300-0413-05	$127.00	$127.00
October 14, 2025	55111-0644-10	$159.70	$159.68
October 14, 2025	29300-0413-05	$127.00	$127.00
November 11, 2025	55111-0644-10	$159.70	$159.68
November 11, 2025	00406-0484-01	$111.02	$111.00
November 11, 2025	29300-0413-05	$127.00	$127.00
December 15, 2025	29300-0413-05	$127.00	$127.00
December 15, 2025	55111-0644-10	$159.70	$159.68
December 15, 2025	43598-0977-10	$18.00	$18.00
December 15, 2025	00406-0484-01	$111.02	$111.00
	Total	$2,723.72	$2,723.44

Requester's Position

"All medications listed were Y-status drugs on the ODG formulary at the time of dispensing and therefore did not require preauthorization. Appeals were submitted after each denial; however, the bills remain unpaid.

Amount In Dispute: $2,723.72

Respondent's Position

The Austin carrier representative for New Hampshire Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on March 2, 2026.

Per 28 Texas Administrative Code Section 133.307(d)(1), if DWC does not receive the response within 14 calendar days of the dispute notification, then 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. 28 TAC Section 134.503 sets out the fee guidelines for services provided by a pharmacy.
3. 28 TAC Sections 134.530 and 134.540 set out the preauthorization requirements for pharmaceutical services.

Adjustment Reasons

The insurance carrier denied payment for the disputed services with the following reasons:

- 5264 – Payment is denied-service not authorized.
- 197 – Payment denied/reduced for absence of precertification/authorization.
- 60 (B13) – The 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.
- HE75 – Prior authorization required to process this bill.
- HEA1 – Claim/service denied.

Issues

1. What is DWC considering in this medical fee dispute?
2. Are the insurance carrier's denials supported?
3. What rule applies to reimbursement of prescribed medication?
4. Has DWC determined whether reimbursement is due to the requester.

Findings

1. The requester seeks reimbursement of prescribed medication for dates of service May 23, 2025 through December 15, 2025 in the amount of $2,723.72 for the following medications.

- Omeprazole – NDC 55111-0158-10
- Acetamin/COD – NDC 00406-0484-01
- Cyclobenzaprine – NDC 29300-0413-05
- Diclofenac Sodium – NDC 43598-0977-10

The medications were denied for lack of prior authorization and as a duplicate. The insurance carrier did not respond to this request for MFDR in support of these denials.

2. The rule specific to prior authorization of medications is found in 28 TAC 134.530(b)(1)(A) which states, Preauthorization for claim subject to the division's closed formulary. 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.

   (B) any prescription drug created through compounding; and

   (C) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but that is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

   Review of the applicable Appendix A found the following.

   - Omemprazole – "N" drug
   - Acetamin/COD – "N" drug
   - Cyclobenzaprine – "N" drug
   - Diclofenac Sodium – "N" drug

   Based on these findings each of these medications did not require prior authorization per Appendix A and insufficient evidence was found to support each was compounded or considered investigational or experimental. The insurance carrier's denial is not supported and will not be considered in this review.

3. The reimbursement of the medications in dispute is calculated per 28 TAC Section 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: ((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;

Medication	NDC number	AWP/Units	Total AWP	Billed Amount	Lesser of AWP and billed amount
Omeprazole	55111015810	4.15/30	$159.68	$159.70	$159.68
Acetamin/Cod	00406048401	1.42/60	$111.00	$111.02	$111.00
Cyclobenzaprine	29300041305	1.64/60	$127.04	$127.00	$127.00
Diclofenac Sodium	43598097710	0.143/100	$21.98	$18.00	$18.00

4. Based on the applicable rules shown above each medication has a recommended amount as shown below.

    - Omemprazole – $159.68 for dates of service May 23, 2025, June 20, 2025, July 21, 2025, August 18, 2025, September 16, 2025, October 14, 2025, November 11, 2025 and December 15, 2025. ($159.68 x 8 = $1,277.44)

    - Acetamin/COD – $111.00 for dates of service June 20, 2025, July 21, 2025, August 18, 2025, September 16, 2025, November 11, 2025 and December 15, 2025. ($111.00 x 6 = $666.00)

    - Cyclobenzaprine – $127.00 for dates of service June 20, 2025, July 21, 2025, August 18, 2025, September 16, 2025, October 14, 2025, November 11, 2025 and December 15, 2025. ($127 x 6 = $762)

    - Diclofenac Sodium – $18.00 for date of service December 15, 2025

    - Total MAR of disputed services ($1,277.44 + $666.00 + $762.00 + $18.00 = $2,723.44. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence the 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 reimbursement is due.

Order

Under Texas Labor Code Sections 413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that New Hampshire Insurance Co must remit to EZ Scripts $2,723.44 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	May 29, 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.