TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

EZ Scripts, LLC

Respondent Name

Everest Premier Insurance Co

MFDR Tracking Number

M4-26-1980-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

March 16, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
August 6, 2025	70868091010	$1,183.90	$1,183.90
August 13, 2025	72205001390	$636.02	$636.02
September 3, 2025	70868091010	$1,183.90	$1,183.90
October 3, 2025	70868091010	$1,183.90	$1,183.90
October 6, 2025	72205001390	$952.04	$952.04
November 3, 2025	70868091010	$1,183.90	$1,183.90
November 3, 2025	72205001390	$952.04	$952.04
December 1, 2025	70868091010	$1,183.90	$1,183.90
December 1, 2025	72205001390	$952.04	$952.04
December 29, 2025	70868091010	$1,183.90	$1,183.90

December 29, 2025	72205001390	$952.04	$952.04
	Total	$11,547.58	$11,547.58

Requester's Position

"The medications Methocarbamol and Pregabalin were prescribed for the treatment of the patient's compensable injuries. At all relevant times, both medications were classified as &-status drugs under the ODG formulary. The assigned adjuster has confirmed that there is no PLN-11, peer review, or IME on file disputing medical necessity or denying this course of treatment … Reconsideration requests were submitted for each date of service; however, no payment or formal written denial was received in response."

Amount In Dispute: $11,547.58

Respondent's Position

"Our bill audit company has determined that no further payment is due … Continued treatment is unrelated to the work injury."

Response Submitted By: Gallagher Bassett

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

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

1. A1 – Claim/Service denied. Final Escalation Reached.
2. P4 – Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment.
3. 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

4. 666 – Reason code not found

Issues

1. What is DWC considering in this medical fee dispute?

2. Is the insurance carrier's denial based on compensability or relatedness supported?

3. Is the requester entitled to reimbursement?

Findings

1. The requester is seeking reimbursement for drugs dispensed from August 6, 2025, through December 29, 2025. The insurance carrier denied payment based on compensability. DWC will review this dispute in accordance with relevant rules.

2. The insurance carrier denied the services in dispute stating, "Claim/Service denied. Final Escalation Reached." The denial also included, "Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment."

   In its position statement, the respondent argued, "Continued treatment is unrelated to the work injury." 28 TAC Section 133.307(d)(2)(H) states,

   "If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier must attach any related Plain Language Notice in accordance with §124.2 of this title (concerning Insurance Carrier Reporting and Notification Requirements)."

   The documentation submitted to DWC does not include a Plain Language Notice. DWC finds no evidence that the claim was adjudicated as not compensable. DWC finds that this denial reason is not supported.

3. Because the insurance carrier failed to support its denial, the requester is entitled to reimbursement.

   The reimbursement considered in this dispute is calculated according to 28 TAC §134.503(c)(1)(A), with relevant formula for generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount.

   - Methocarbamol 500 mg tablets: (15.732 x 60 x 1.25) + $4.00 = $1,183.90 per dispense. The requester is seeking this amount for six dates of service. This amount is recommended.
   - Pregabalin 75 mg capsules: (8.42733 x 60 x 1.25) + $4.00 = $636.05 per dispense. The requester is seeking $636.02 for one date of service. This amount is recommended.
   - Pregabalin 75 mg capsules: (8.42733 x 90 x 1.25) + $4.00 = $952.07 per dispense. The requester is seeking $952.04 for four dates of service. This amount is recommended.

   The total allowable reimbursement is $11,547.58. 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 Everest Premier Insurance Co must remit to EZ Scripts $11,547.58 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	June 26, 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.