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
Proximarx

Respondent Name
Starr Indemnity & Liability Co

MFDR Tracking Number
M4-25-2181-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 9, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 9, 2024	71101-0010-06	$102.45	$0.00

Requester's Position

"The above claimant received medication, but the carrier has not acknowledged receipt of service. Reimbursement should be made to the provider if the claim has been submitted within 95th day after the date on which the healthcare service was rendered. The original bill was submitted to an received by carrier on **08/31/2024 via CERTIFIED MAIL**."

Supplemental response submitted July 22, 2025

"We received a partial payment for PS. The amount received $15.89 does not cover pharmacy cost of the medication."

Amount in Dispute: $102.45

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: We have escalated the bills in question for manual review to determine if additional monies are owed. We will provide a supplemental response once the bill auditing company has finalized their review."

Response submitted by: Gallager Bassett

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.503 sets out the fee guidelines for pharmacy services.
3. 28 TAC §133.10 sets out required billing forms/formats for pharmacy bills.

Denial Reasons

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

Issues

1. What rule is applicable to reimbursement?
2. Is the requester entitled to reimbursement?

Findings

1. The requester seeks reimbursement of pain relief 4% Lido Patch (Theracr) dispensed August 9 2024.

   DWC Rule 28 TAC §134.503 (b) states, "For coding, billing, reporting, and reimbursement of prescription drugs and nonprescription drugs or over-the-counter medications, Texas workers' compensation system participants must comply with Chapters 133 and 134 of this title (General Medical Provisions and Benefits--Guidelines for Medical Services, Charges, and Payments, respectively).

   DWC Rule 28 TAC §133.10 (3)(R) states in pertinent parts, "The following data content or data elements are required for a complete pharmacy medical bill related to Texas workers' compensation health care: generic National Drug Code (NDC) code (DWC-066/field 21) is required when a generic drug was dispensed or if dispensed as written code '2' is reported in DWC-066/field 19;"

Review of the submitted DWC066 indicates Generic NDC 71101-0010-06 in field 21. Review of the Food and Drug Administration NDC look-up at www.National Drug Code Directory | FDA found, "There are no product published" for this NDC number.

2. The division finds that the NDC number provided on the DWC-066 (field 21) for the 4% Lidocaine Pain Relief Patch (Theracr) is not listed in the published database, reimbursement is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester and the respondent 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 §§413.031 and 413.019, DWC has determined the requester is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		July 30, 2025
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 §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 electronico CompConnection@tdi.texas.gov.