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

Requestor Name
Crescent Medical Center

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-24-2056-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
May 23, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 7, 2023	72040	$168.51	$0.00
September 7, 2023	72141	$454.39	$0.00
	Total	$622.90	$0.00

Requestor's Position

"We are requesting the MAR value of $622.90. BCBS originally paid $406.69 and recouped due to work comp insurance found. Texas Mutual denied our bill stating another entity was paid. Texas Mutual owes the facility the MAR amount of $622.90."

Amount in Dispute: $622.90

Respondent's Position

"BlueCross BlueShield (BCBS) paid Lancaster Regional Hospital $406.09 on 10/3/2023 and submitted a DWC-26 to the carrier on 12/5/2023. Texas Mutual issued payment to BCBS on 1/8/2024, under check #03729421 for $406.69 in accordance with 409.0091 (Attachment). BCBS requested refund of services paid to the requestor and the requestor is asking that the carrier issue payment per MAR value of $622.90… Reimbursement was issued in accordance with Labor Code Texas Workers' Compensation Act 409.0091 (h) for each medical benefit paid, the workers' compensation charrier shall pay to the health care insurer the lesser of the amount payable under

the applicable fee guideline as of the date of service or the actual amount paid by the health care insurer. The requestor should seek refund from BCBS as TSM paid BCBS for the services in dispute. Please contact BCBS for payment."

Response submitted by: Texas Mutual Insurance Co

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 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §140.8 sets out the procedures for Health Care Insurers to Pursue Reimbursement of Medical Benefits under Labor Code 409.0091.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 926 – Payment was made to BCBS for these service, contact BCBS for your payment.
- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC – 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- DC4 – No additional reimbursement allowed after reconsideration.
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 926 – Request for reimbursement was previously submitted by another entity. Refer to Rule 140.8 (l).
- CAC-P12 – Workers; compensation jurisdictional fee schedule adjustment.

Issues

1. Is the respondent's position supported?

Findings

1. The requestor seeks reimbursement for facility services rendered on September 7, 2023. The requestor billed Blue Cross Blue Shield (private health insurer) and was reimbursed the amount of $406.69. The requestor identified the claim as a workers compensation claim and then proceeded to bill Texas Mutual for disputed date of service September 7, 2023. Texas Mutual indicates that payment is not due to the requestor, because payment has been issued to Blue Cross Blue Shield pursuant to a DWC-26 request for reimbursement submitted to Texas Mutual.

   28 TAC §140.8 states in part, "(i) Multiple Entities Seeking Reimbursement for Same Services. If there are multiple entities seeking reimbursement for the same services and dates of services for the same health care insurer for the same injured employee, the following apply: (1) When the workers' compensation insurance carrier obtains a release from the health care insurer indicating that those specific services have been paid in full, no other entity may collect for those specific services. (2) If a dispute remains over the fees to be paid for those specific services, the first in time to file a dispute with the Division is the only subclaimant that has a right to dispute resolution, and reimbursement, for that injured employee's claim and those specific services rendered unless that subclaimant abandons the dispute resolution process prior to a final adjudication of the issues."

   To determine if the requestor is entitled to reimbursement the DWC considered the following:

   - MFDR received the DWC60 on May 23, 2024
   - The disputed date of service is September 7, 2023.
   - The requestor seeks reimbursement in the amount of $622.90.

   Blue Cross Blue Shield (BCBS)

   - BCBS submitted a DWC-26 to Texas Mutual Insurance Company on December 5, 2023.
   - BCBS received a payment in the amount of $406.69 from Texas Mutual which was issued to Health Care Service Corp on January 8, 2024.

   Healthcare provider / Requestor

   - Disputed date of service September 7, 2023
   - BCBS issues a payment in the amount of $406.69 to the requestor on October 3, 2023.
   - HCP submits a copy of a medical bill (UB-04) with a "creation date" February 6, 2024.
   - The DWC finds no medical bill was submitted to support that the medical services were billed to Texas Mutual prior to the date that BCBS requested reimbursement from Texas Mutual (December 5, 2023).

The DWC finds that the requestor submitted insufficient documentation to support that the medical bills were submitted to Texas Mutual prior to the date that BCBS requested reimbursement from Texas Mutual.

Pursuant to 28 TAC §140.8 (i) the DWC finds that the requestor is not entitled to reimbursement for the services in dispute. As a result, the requestor is entitled to $0.00 for disputed date of service September 7, 2023.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 19, 2024 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.