



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Methodist Health Systems

Respondent Name

Texas Municipal League Intergovernmental

MFDR Tracking Number

M4-25-2624-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

June 23, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 13, 2024	Emergency Visit	\$721.95	\$0.00

Requester's Position

"Requesting review of unpaid date of service. Bill and appeal denied as duplicate"

Amount in Dispute: \$721.95

Respondent's Position

"When the carrier received the provider's UB-04, it responded on its EOB that it had previously reimbursed Blue Cross Blue Shield.

The provider has billed both a healthcare carrier and a worker's compensation carrier. It has received payments from the healthcare carrier. Once it received payment from the healthcare carrier, the healthcare carrier then sought reimbursement from the worker's compensation carrier. The healthcare carrier stepped into the shoes of the healthcare provider once the healthcare carrier had paid the provider. The provider is not entitled to subsequently pursue reimbursement from a second source, i.e. the worker's compensation carrier without first reimbursing the healthcare carrier and then allowing the healthcare carrier to reimburse the worker's compensation carrier. As it stands, the worker's compensation carrier has already paid the provider through the healthcare carrier in the process set out through the DWC 26 procedure.

Accordingly, the provider should withdraw its request for Medical Fee Dispute Resolution. It should not be entitled to Medical Fee Dispute Resolution until and only if it reimburses Blue Cross Blue Shield and Blue Cross Blue Shield reimburses the worker's compensation carrier for monies that the worker's compensation carrier previously paid to Blue Cross Blue Shield under the DWC 26 procedure."

Response Submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

This medical fee dispute is decided according to [Texas Labor Code \(TLC\) §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. [28 Texas Administrative Code \(TAC\) §133.305](#) Medical Dispute Resolution-General
2. [28 TAC §133.307](#) Medical Fee Dispute Resolution
3. [28 TAC §140.8](#) Procedures for Health Care Insurers to Pursue Reimbursement of Medical Benefits under Labor Code 409.0091
4. [Texas Labor Code 409.0091](#) Reimbursement Procedures for certain Entities
5. [28 TAC §141.1](#) Requesting and Setting a Benefit Review Conference.

Denial Reasons

The insurance carrier reduced or denied payment for the disputed services with the following claim adjustment codes:

- 18 – Exact duplicate claim/service.
- 224 – Duplicate charge.
- 375 – Please see special *Note* below.
- P12 – Workers compensation jurisdictional fee schedule adjustment.
- Note: Paid to Blue Cross & Blue Shield 12/20/24, bill...Check...

Issues

1. Is the insurance carrier's denial of reimbursement supported?

Findings

1. The requester is seeking reimbursement in the amount of \$721.95 for emergency room services rendered on August 13, 2024. The requester states: "Requesting review of unpaid date of service. Bill and appeal denied as duplicate."

Upon review, the workers' compensation insurance carrier responded that reimbursement for these services had already been issued to Blue Cross Blue Shield, based on the provider's submitted UB-04 claim form and the corresponding Explanation of Benefits (EOB).

Pursuant to 28 Texas Administrative Code (TAC) §140.8(i)(1), if a workers' compensation insurance carrier obtains confirmation from a health care insurer that full payment has been made for specific services, no additional party may pursue reimbursement for those same services. In this case, Blue Cross Blue Shield submitted a request for payment to the workers' compensation insurance carrier and was reimbursed accordingly. Therefore, under 28 TAC §140.8(i)(1), payment for these services is not recommended.

Additionally, 28 TAC §140.8(i)(2) provides that if a dispute arises regarding payment for specific services, only the first subclaimant to file a dispute with the Division has the right to pursue dispute resolution and seek reimbursement for those services, unless that subclaimant withdraws from the process before a final determination is made.

In this case, however, Blue Cross Blue Shield has already been reimbursed for the same services the requester is now seeking payment for. Therefore, the Division of Workers' Compensation (DWC) finds that reimbursement cannot be recommended for the services rendered on August 13, 2024.

Conclusion

The resolution of this medical fee dispute is based on the evidence submitted by both the requester and the respondent. While not all the documentation was discussed in detail here, all relevant information was carefully reviewed and considered. Based on the findings, the Division of Workers' Compensation (DWC) concludes that the requester has not demonstrated entitlement to reimbursement for the referenced date of service.

Accordingly, no payment is due for the August 13, 2024 date of service.

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

Signature

Medical Fee Dispute Resolution Officer

September 25, 2025
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 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 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 512-804-4812.