Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address:	MFDR Tracking #: M4-11-2018-01
TEXAS HEALTH FORT WORTH 500 E BORDER 11TH FLOOR ARLINGTON TX 76010	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:	Date of Injury:
TEXAS MUTUAL INSURANCE CO Box #: 54	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This patient was seen at our facility emergency room on 8/25/2010 as a result of a work related injury on 7/1/2008. We billed this patient's workers comp insurance, Texas Mutual and received a denial which stated this is not treating doctor approved treatment, that the documentation does not support an emergency, and that this provider was not certified to be paid for this procedure on this date of service. We filed a request for reconsideration to Texas Mutual and received another denial. Per Sec. 413.014(b) treatments and services for a medical emergency do not require express preauthorization."

Amount in Dispute: $234.50

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The claimant admitted himself to the emergency room at the requestor's facility in the early afternoon of 8/25/10. He reported burning in his legs past month. The emergency room physician took a history then performed a physical exam. The history revealed low back surgery on 7/8/10, some 6 weeks prior to the emergency room visit. The history also revealed the claim taking the medication, Griseofulvin, for toe fungus the past month. The exam findings were completely negative. Texas Mutual means this not in the weak sense that there was an absence of findings as it related to potential involvement of the low back but in the strong sense that the entire exam showed the claimant to be completely normal. The requestor's documentation reflects under the header, Medical Decision Making, Rechecks/ED Course/Consults, the following: "1:00 PM D/w Nolan, pharmacy. States Griseofulvin cause peripheral neuropathy. 1:41 PM Rechecked pt. D/w pt findings and plans with aid of an interpreter. Instruction pt to d/c use of Griseofulvin, and to f/u with a PCP…" In other words the emergency room physician contacted the facility's inhouse [sic] pharmacy and discussed with the pharmacy the side effects of the fungus medication, Griseofulvin. The documentation indicates the physician was made aware of a side effect of this medication, peripheral neuropathy- "burning in his legs past month." The physician then discussed this with the claimant and told the claimant to stop taking the medication. Texas Mutual denied payment to the requestor for two reasons. First, the treatment was not an emergency in terms of the definition of such as DWC Rule 133.2. Second, the admission did not appear to have been approved or recommended by the treating doctor. Rule 134.600 indicates that a non-surgical admission does not require preauthorization. Absent such, a medical emergency is not necessary to establish liability of payment *as it relates to 134.600.* Nevertheless, the documentation does not substantiate a medical emergency with respect to Rule 133.2. And this is important because medical emergency is a requirement of DWC Rule 180.22. Rule 180.22 states at (c), "The treating doctor is the doctor primarily responsible for the efficient management of health care and for coordinating the health care for an injured employee's compensable injury. The treating doctor shall: (1) except in the case of an emergency, approve or recommend all health care reasonable required that is to be rendered to the injured employee including, but no limited to, treatment or evaluation provided through referrals to consulting and referral doctors or health care providers, as defined in this section…" The requestor's documentation indicates the admission was a self-referral. The requestor's documentation does not meet the 133.2 definition of medical emergency. The requestor's documentation identifies the claimant came to the emergency room before 1 p.m. and not 1 in the morning. The requestor's documentation provides no mitigating reason why the claimant did not contact the treating doctor concerning his symptom of "burning legs." Because the admission was a self-referral and

the treatment was not a medical emergency it required treating doctor approval. There is no evidence the treating doctor approved or recommended the treatment provided by the requestor. ”

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
08/25/2010	CPT Code 99282	N/A	$234.00	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for hospital outpatient services.

This request for medical fee dispute resolution was received by the Division on January 31, 2011.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - CAC-B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.
   - CAC-W1 – Workers Compensation State Fee Schedule adjustment.
   - 242 – Not treating doctor approved treatment.
   - 899 – Documentation and file review does not support an emergency in accordance with Rule 133.2.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 891 – No additional payment after reconsideration.
2. Division rule at 28 TAC §134.403(e) states, in pertinent part, that “Regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;”
3. Pursuant to Division rule at 28 TAC §134.403(f), “The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.”
4. Under the Medicare Outpatient Prospective Payment System (OPPS), all services are classified into groups called Ambulatory Payment Classifications (APCs). Services in each APC are clinically similar and require similar resources. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Packaged services are considered integral to the primary paid service and are not separately reimbursed. An OPPS payment status indicator is assigned to each HCPCS code. The status indicator for each HCPCS code is shown in OPPS Addendum B, and a full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year, both of which are publicly available from the Centers for Medicare and Medicaid services.
5. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:
   (1) No documentation was found to support a contractual agreement between the parties to this dispute;
   (2) MAR can be established for these services; and
   (3) Separate reimbursement for implantables was NOT requested by the requestor.

6. CPT Code 99282 is considered to be a status “V” code. Status “V” codes are considered clinic or emergency department visit; may include ER physician or personal physicians. According to the emergency department record the claimant went to the emergency department at 1 p.m. with “burning legs”. According to the emergency department records the claimant was taking a prescription medication for the treatment of a fungal infection of the toe. It was discovered by the emergency room physician that one of the side effects of the medication was peripheral neuropathy. At this time the physician explained to the claimant the side effects and instructed the patient to discontinue the use of the medication. There were no records submitted to support a medical emergency as required by Rule 133.2 (3)(A) nor that the treating doctor referred the claimant to the emergency department for treatment as required by Rule 180.22.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code §413.031(c), the Division concludes that the requestor is not due payment. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §180.22, §133.2, §133.305, §133.307, §134.403
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.