Texas Department of Insurance, Division of Workers' Compensation
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: Dr. Glenn J. Bricken 25810 Oak Ridge Dr. The Woodlands, TX 77380	MFDR Tracking #: M4-07-2064-01 DWC Claim #: Injured Employee:
Respondent Name: Travelers Property & Casualty Box #: 05	Date of Injury: Employer Name: Toys R Us Holding Inc. Insurance Carrier #: 478CBAAR4227

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: Per Requestor's Table of Disputed Services, "Facility is now CARF accredited."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: Requestor did not submit a Position Summary to MFDR.

Principle Documentation:

1. None

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
07/31/06 – 08/21/06	No EOB - DUPL	97799-CP CA	1, 2, 3	$2,200.00
08/22/06 – 09/01/06	No EOB – DUPL	97799-CP CA	1, 4, 5	$1,800.00
Total Due:				$4,000.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, Reimbursement Policies and Guidelines, and Division Rule 134.202 titled, Medical Fee Guideline effective August 1, 2003, sets out the reimbursement guidelines.

1. On December 6, 2006, the carrier acknowledged receipt of the Notice of Medical Dispute Resolution. On December 18, 2006, the carrier acknowledged receipt of the letter requesting additional information. On April 2, 2007, and April 5, 2007, phone calls were placed to the Respondent requesting EOBs for this dispute. As of April 9, 2007 Medical Fee Dispute Resolution has not received a response to the DWC-60, nor any additional documentation, therefore this dispute will be reviewed per the Medical Fee Guideline.

2. CPT code 97799-CP-CA was billed for dates of service 07/31/06 – 08/21/06: The reconsideration EOB was denied as "DUPP" (Duplicate claim/service. These services have already been considered for reimbursement, and "DUPL" (Duplicate claim/service. Duplicate charges).

3. The Requestor received approval, dated 07/24/106, for chronic pain management for dates of service 07/21/06 – 08/21/06 from the Respondent. The Respondent made partial payments for each session. Per Rule 134.202 (e) (5) (i) The hourly reimbursement for a CARF accredited program shall be 100% of the MAR. Per Rule 134.202 (E) (ii); reimbursement for a CARF accredited program shall be $125.00 per hour; therefore reimbursement is recommended in the amount of **$2,200.00 ($125.00 X 100% = $125.00 (MAR) X 8 (Hours) = $1,000.00 - $800.00 (Carrier payment) = $200.00 X 11 DOS = $2,200.00.**

4. CPT code 97799-CP-CA was billed for dates of service 08/22/06 – 09/01/06: The reconsideration EOB was denied as "DUPP" (Duplicate claim/service. These services have already been considered for reimbursement. And "DUPL" (Duplicate claim/service. Duplicate charges).

5. The Requestor received approval, dated 08/10/06, for chronic pain management for dates of service 08/10/06 – 09/10/06 from the Respondent. The Respondent made partial payments for each session. Per Rule 134.202 (e) (5) (i) The hourly reimbursement for a CARF accredited program shall be 100% of the MAR. Per Rule 134 (E)(ii); reimbursement for a CARF accredited program shall be $125.00 per hour; therefore reimbursement is recommended in the amount of **$1,800.00 ($125.00 X 100% = $125.00 (MAR) x 8 (Hours) = $1,000.00 - $800.00 (Carrier payment) =$200.00 X 9 DOS = $1,800.00)**

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $4,000.00 plus accrued interest, due within 30 days of receipt of this Order.

Decision & Order

05/24/07

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. §413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision, that is the subject of the appeal, is final and appealable. The Division is not considered a party to the appeal.

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