TEXAS WORKERS' COMPENSATION COMMISSION
MEDICAL REVIEW DIVISION, MS-48
MEDICAL DISPUTE RESOLUTION
FINDINGS AND DECISION

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER: SOAH DOCKET NO. 453-04-1160.M5

Main Rehab and Diagnostic **3710 Rawlins Street Suite 1400** **Dallas TX 75219** **Requestor** **V.** **American Zurich Ins** **Box 19** **Respondent**	§ § § § § § § § § § § §	**MDR TRACKING #: M5-03-3103-01** **TWCC FILE #:** **CLAIMANT:** **DOI:** **SERVICE FROM: 2-7-03** **SERVICE TO: 4-29-03**

Si prefiere hablar con una persona de habla hispana acerca de esta correspondencia sirvase llamar al 1-512-804-4812.

The Medical Review Division reviewed the decision of the Independent Review Organization (IRO) in the captioned medical dispute and concludes the dispute with the enclosed Decision.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within **20** days of your receipt of this decision (28 Tex. Admin. Code § 148.3). This Decision is deemed received by you five days after it was mailed and the first working day after the date this Decision was placed in the carrier representative's box (28 Tex. Admin. Code § 102.5 (d)). A request for hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P. O. Box 17787, Austin, Texas 78744, or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of this written request for a hearing to the opposing party involved in the dispute.

I hereby verify that a copy of this Findings and Decision was placed in the insurance carrier representative's box and mailed to the requestor applicable to Commission Rule 102.5 this _____ day of _____, 2003. Per Commission Rule 102.5(d), the date received is deemed to be five days from the date mailed and the first working day after the date this Decision was placed in the carrier representative's box.

Signature of Commission Employee: _____

Printed Name of Commission Employee: _____

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 7-28-03.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the FCE, work hardening program, and office visits were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service from 2-7-03 through 4-29-03 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 9th of October 2003.

Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt