THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:
SOAH DOCKET NO. 453-03-1532.M5

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

White Rock Open MRI **611 S. Congress Avenues, Suite 420** **Austin, TX 78704** **Requestor** **V.** **P.O. Box 400** **Austin, TX 78767-0400** **Respondent**	§ § § § § § § § § § § § §	**MDR TRACKING #: M5-02-3236-01** **TWCC FILE #:** **CLAIMANT:** **DOI:** **SERVICE OF:**

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 and Order.

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 within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code § 148.3). This Decision is deemed received by you 5 (five) days after it was mailed and the first working day after the date this Decision was placed in the carrier representatives box (28 Tex. Admin. Code § 102.5 (d). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P. O. Box 40669, Austin, Texas, 78704-0012. 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 all other parties 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 _____, 2002. Per Commission Rule 102.5(d), the date received is deemed to be 5 (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 January 1, 2002 and Commission Rule 133.305 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 Medical Review Division has reviewed the IRO decision and determined that **the Respondent prevailed** on the issues of medical necessity. Therefore in accordance with §133.308(q)(9), the Commission hereby **Declines to Order** the respondent to reimburse the **Requestor** for the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The disputed MRI was found to **not** be medically necessary. The respondent raised no other reasons for denying reimbursement for these services.

This Decision is applicable to date of service 10/18/01 in this dispute.

This Decision is hereby issued this _____ day of, _____ 2002.

Medical Dispute Resolution Officer
Medical Review Division

TEXAS
WORKERS' COMPENSATION COMMISSION
SOUTHFIELD BUILDING, MS-48, 4000 SOUTH IH-35, AUSTIN, TEXAS 78704-7491
(512) 804-4800

MEMORANDUM

DATE: ____/_____/._____

TO: **Austin Commission Representative, David Wagner, Box 12**

CARRIER: **Risk Management Fund**

FROM: **Medical Review Division, 8th Floor, Suite 814**

RE: **NOTICE of Independent Review Organization and Medical Dispute Resolution Decision**

This memorandum shall serve as your notice to present yourself to the Mail Room Service Counter:

(X) An IRO and MDR Decision.

The above referenced document has been issued in a medical dispute case review pertaining to the following claimant and insurance carrier:

IDENTIFIER

MDR TRACKING #: M5-02-3236-01
TWCC FILE #:
CLAIMANT: .
DOI:

I, the undersigned Representative of the above referenced insurance carrier, do hereby acknowledge receipt of the IRO and MDR Decision applicable to a medical dispute resolution request solicited by the requestor.

Receipt of this Decision is hereby acknowledged this ____ day of _____ 2002.

Signature of Commission Representative: _____

Printed Name of Commission Representative: _____