

December 19, 2002

Re: Medical Dispute Resolution  
MDR #: M2-03-0267-01  
IRO Certificate No.: IRO 5055

Dear:

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the medical records to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Anesthesia and Pain Management.

I am \_\_\_ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by \_\_\_ is deemed to be a Commission decision and order.

Clinical History:

This 30-year-old male claimant sustained an injury to the 8<sup>th</sup> rib while on his job on \_\_\_\_\_. An RME on 03/24/02 revealed that the patient had an FCE on 02/18/02, and was at the physical-demand level that his job required.

Disputed Services:

Work hardening program.

Decision:

The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that the program in question is not medically necessary in this case.

Rationale for Decision:

There is no apparent reason why an injury such as this would persist this long. The rib fracture was not identified on an x-ray. There was no displacement of the rib. The injury was identified only on a bone scan done some time after the injury, which showed evidence of a healing rib fracture. A work hardening program at this time would not benefit the patient in returning to his job. The records indicate that the patient was at the physical-demand level that his job requires.

**YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within ten (10) days of your receipt of this decision (28 Tex. Admin. Code 142.5©).

**If disputing other prospective medical necessity (preauthorization) decisions** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within twenty (20) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings  
Texas Workers' Compensation Commission  
P.O. Box 40669  
Austin, TX 78704-0012

**A copy of this decision should be attached to the request.** The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

**I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on December 19, 2002.**

Sincerely,