

Core 400 LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/24/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Peripheral Nerve Neuroplasty with Fluoroscopy

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

MD, Board Certified in Physical Medicine and Rehabilitation\
Board Certified in Pain Management
Board Certified in Electrodiagnostic Medicine
Residency Training PMR and Orthopedic Surgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 2/18/09, 3/2/09
ODG Guidelines and Treatment Guidelines
Pain Consultants, 4/16/08, 1/21/09
Assessment, 10/22/08, 1/21/09, 7/23/08
Diagnostic Clinic, 1/21/09, 4/17/08, 7/23/08, 10/22/08

PATIENT CLINICAL HISTORY SUMMARY

This is a man injured in xxxx. The records indicate he underwent surgery including a spinal fusion. He suffers from post-laminectomy syndrome. He had a dorsal column stimulator inserted (date not clear). He began developing electrical pain at the stimulator site. Dr. (1/21/09) advised his Nurse Practitioner that the patient would need to have an injection of Wydase to break up scar tissue.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

The procedure requested is a peripheral and not an intraspinal procedure. Spinal stimulators that initially work and then malfunction can be related to wire breakage, movement, etc. The records indicate that the provider in this instance is trying to determine the cause of the malfunction, and considers scar tissue as a possibility. An X-Ray of 10/22/08 shows the wire

in place, but there are no comparative X-Rays to check for electrode migration in the records provided for this review. The records suggest the short circuit may be due to the impedance changes due to the scar tissue. The ODG does not address this issue specifically. While it is not certain that the chemical neuroplasty will be sufficient, the alternative in this case is a surgical procedure. It is for this reason that the reviewer finds there is a medical necessity for the procedure. The reviewer finds that medical necessity exists for Peripheral Nerve Neuroplasty with Fluoroscopy.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)