

# Core 400 LLC

An Independent Review Organization  
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**DATE OF REVIEW:**

May/26/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Sternum Fracture Repair Outpt 21899, 21825, 64421

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

M.D., board certified in 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**

**PATIENT CLINICAL HISTORY SUMMARY**

This is an injured worker who apparently fell. He sustained a fracture of the sternum, apparently nondisplaced. He has had conservative care, including chiropractic care at and various physical therapy modalities. He remains, according to the history and records, to have chronic pain on a daily basis, and takes narcotics to help control this pain.

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

The ODG Disability and Treatment Guidelines do not address sternal fractures. The previous reviewer notes that there is a report by and colleagues which would indicate that when a nonunion of a fractured sternum is encountered and debilitating chest pain, an excision of abnormal bone and rigid internal fixation with available use of autologous bone graft should be utilized. The previous reviewer stated that this patient does not have debilitating pain, but only mild tenderness to palpation. However, based on the medical records provided for this

review, it is well documented that the patient has daily pain, takes narcotics which are no longer working, and has "chronic pain." These terms meet the criteria of debilitating pain, and it is for this reason that the previous adverse determination is being overturned. The reviewer finds that medical necessity exists for Sternum Fracture Repair Outpt 21899, 21825, 64421.

**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)  
Report by Burton and colleagues in 2002.