

SENT VIA EMAIL OR FAX ON  
Feb/08/2010

## True Decisions Inc.

An Independent Review Organization  
835 E. Lamar Blvd. #394  
Arlington, TX 76011  
Phone: (214) 717-4260  
Fax: (214) 594-8608  
Email: rm@truedecisions.com

### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Feb/02/2010

**IRO CASE #:**

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

Spinal-Stim Bone Growth Stimulator

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

Board Certified in Physical Medicine and Rehabilitation  
Subspecialty Board Certified in Pain Management  
Subspecialty Board Certified in Electrodiagnostic Medicine  
Residency Training PMR and ORTHOPAEDIC 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**

OD Guidelines  
Denial Letters 12/29/09 and 11/20/09  
OP Report 11/10/09  
Dr. 10/7/09  
Emg 10/7/09  
MRI 8/10/09  
Dr. 11/20/09  
12/16/09 and 1/20/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a man reportedly injured xx/xx/xx. He was found to have multiple level cervical degenerative changes and he underwent a C3-C6 bilateral foraminotomy and anterior fusion on 11/10/09. There is a request for the Orthotix C stimulator.

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

The ODG questions the value of the stimulator. The Patient Advocates note that it is FDA approved and this man has a risk factor from smoking. The ODG does consider the possibility of its use when there are multiple levels of fusion involved and in a smoker. The most recent notes are the operative report from 11/10/09, nearly 3 months ago. The reviewer saw no medical notes that are more recent. There are the advocate notes since surgery. The reviewer did not see any medical reports of a delayed or failed union. The ODG advises a case by case decision. The reviewer does not see the medical necessity at this late time without knowing if there are post operative signs of delayed healing of the arthrodesis. The study cited in the manual for the device recommends utilizing the device for "four hours per day for a minimum of three months..." but up to 6 months at the surgeon's discretion. We are 1 week short of 3 months. Without any information from the surgeon suggesting a non or delayed union, the reviewer medical assessment is the equipment is not medically necessary at this time.

**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)