

SENT VIA EMAIL OR FAX ON  
May/11/2010

## 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:**

May/10/2010

**IRO CASE #:**

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

Implantation of Spinal Cord 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 3/10/10 and 3/31/10  
Dr. 0/15/09 thru 4/19/10  
BBH12 3/16/10

**PATIENT CLINICAL HISTORY SUMMARY**

This lady was apparently injured in xxxx. There are no early records. She underwent a laminectomy and 2 fusions by 1998. She was managed by different pain medications with problems tolerating some. She stopped some for fear of addiction. She was apparently dismissed for non-compliance once. Dr. noted SI pain, myofascial pain and failed back syndrome. He advised a spinal stimulator. He felt that there were no contraindication to a

stimulator trial. There was no formal psychological assessment, but he performed a Brief Battery for Health Improvement-II. He noted that it showed a high level of somatic complaints and functional complaints (3/16/10)

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

The ODG does recommend spinal stimulators for failed back syndrome. A psychological assessment is necessary to determine "realistic expectations." The presence of the somatic and functional complaints would suggest that this would not be appropriate. Without the psychological assessment, the request is not medically necessary.

**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)