P-IRO Inc.

An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #203
Mansfield, TX 76063
Phone: (817) 405-0855
Fax: (214) 276-1787
Email: resolutions.manager@p-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:
Jan/15/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Trial Spinal Cord Stimulator and Permanent Implantation if Trial is Successful

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

REVIEW OUTCOME:

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

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
MRI left shoulder 05/11/10
Electrodiagnostic studies 04/21/11
MRI left shoulder 09/20/11
Partial psychological evaluation 07/25/12
Clinical record 08/02/12
Clinical record 08/15/12
Clinical record 02/14/13
Clinical record 06/24/13
Clinical record 07/18/13
Clinical record 08/21/13
Letter of medical necessity 10/28/13
Prior utilization reports 09/16/13-12/05/13

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male who sustained an injury on xx/xx/xx. No specific mechanism of injury was noted. It appeared that the patient was previously approved for a spinal cord stimulator trial; however, the patient opted out of the trial and moved out of the country. The patient returned for follow up in February of 2013. The patient continued to report pain in the left shoulder. Physical examination at this visit was within normal limits. Medications continued at this visit included Norco 10/325mg. The patient returned for follow up on 06/24/13 and continued to report complaints of intermittent left knee and shoulder pain following a prior left

rotator cuff repair. Based on physical examination there were no substantial findings. The patient was using Lidoderm and Norco at this visit. Follow up on 07/19/13 stated the patient continued to report left shoulder pain despite the use of medications and physical therapy. Physical examination at this visit was limited. The patient had an arthrogram injection at this visit. Follow up on 08/21/13 stated the patient had minimal relief from prior injections and described more relief with prior stellate ganglion blocks. Physical examination at this visit was again unremarkable. The patient was recommended for a spinal cord stimulator trial, psychological evaluation, and psychometric testing. The letter indicated the patient had improvement following stellate ganglion blocks. The requested spinal cord stimulator placement trial and subsequent placement depending on trial results was non-certified by utilization review on 11/08/13. The report indicated that there was limited documentation regarding non-operative treatment. There was also limited finding regarding CRPS. The request was again denied by utilization review on 12/05/13 as there was no updated psychological evaluation.

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

The clinical documentation submitted for review demonstrates that the patient has had continuing complaints of left shoulder pain following rotator cuff repair in December of 2012. The patient's symptoms have not improved with medication management. It was noted that the patient was cleared psychologically for a spinal cord stimulator trial in 2012; however, the patient opted out of performing this trial. No updated psychological evaluations were available for review clearing the patient for further spinal cord stimulator trials. It was also noted from the records that the patient has minimal objective findings regarding persistent CRPS. There was no evidence of allodynia, skin mottling, hyperhidrosis, or temperature changes in the left shoulder that would support a diagnosis of CRPS. Given the lack of clinical documentation supporting the proposed procedures based on guideline recommendations, it is the opinion of this reviewer that medical necessity is not established and prior denials are upheld.

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

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

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES