

# C-IRO Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Mar/23/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Caudal ESI x 1

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

M.D., Board Certified in Pain Management and Anesthesiology under the American Board of Anesthesiologists

**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, 2/15/10, 2/25/10

M.D. 3/3/10, 2/9/10, 11/12/09, 3/3/10, 8/15/07, 7/26/07, 7/25/07, 9/24/07, 10/8/07

xxxxx 9/7/06

xxxxx 9/7/07, 4/11/08

D.C. 4/7/08

xxxxx 2/25/08 to 12/18/07

xxxxx 12/19/08

M.D. 12/19/08

ODG-TWC Low Back Procedure Summary

**PATIENT CLINICAL HISTORY SUMMARY**

The patient complains of pain "primarily in the lower, lower, left, right lumbar spine." It radiates "to the left anterior thigh, lateral lower legs, and feet to the left foot laterally, plantar surface, dorsal surface." "Hyperesthesia in bilateral feet and ankles distribution" is noted in the physical exam. The request is for a caudal ESI "for the pain she is having in her coccyx area."

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

The ODG recommends the use of epidural steroid injections for radicular pains. In this case, the requesting physician specifically states that he is requesting the ESI to treat pain in the "coccyx area." This is not a radicular symptom. A mention of hyperesthesia is noted in the physical exam but not correlated with a specific dermatomal pattern. There is also no discussion about how the MRI performed on 9/7/06 may correlate with the patient's symptoms. Based on the records submitted, this request for ESI does not satisfy the ODG. The reviewer finds that medical necessity does not exist for Caudal ESI x 1.

**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)