

September 11, 2006

PATRICIA DEVRIES  
TX DEPT OF INS DIV OF WC  
AUSTIN, TX 78744-1609

CLAIMANT: \_\_\_  
EMPLOYEE: \_\_\_  
POLICY: M2-06-1820-01  
CLIENT TRACKING NUMBER: M2-06-1820-01

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Medical Review Institute of America (MRIOA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Department of Insurance Division of Workers Compensation has assigned the above mentioned case to MRIOA for independent review in accordance with DWC Rule 133 which provides for medical dispute resolution by an IRO.

MRIOA has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the DWC approved doctor list (ADL). The reviewing provider has no known conflicts of interest existing between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO.

**Records Received:**

Records Received from the State:

- Notification of IRO Assignment, 8/14/06 - 2 pages
- Medical Dispute Resolution Request/Response, 8/14/06 - 2 pages
- Table of Disputed Services, undated - 1 page
- Corvel Denial, 7/3/06-7/17/06 - 4 pages

Records Received from Old Republic Insurance:

- Report of Medical Evaluation, 6/23/06 – 6 pages

Records Received from Texas Back Institute:

- Office Notes, 11/8/05–8/17/06 – 9 pages

**Summary of Treatment/Case History:**

The patient is a 42-year-old male truck driver who was injured at work on \_\_\_ while attempting to hook up a trailer. He complains of constant low back pain and groin pain with intermittent radiation to the left buttock and posterior left thigh. An MRI with gadolinium enhancement was performed on 09/27/05 and demonstrated post-surgical changes consistent with a L4–5 laminectomy, but with no evidence of recurrent disc herniation, spinal stenosis, or neuroforaminal stenosis. There was a mild disc bulge at L5–S1 and mild facet arthropathy without neural impingement. The patient was evaluated by Dr. Stephen Hochshuler on 10/11/05 and concern regarding L4–5 instability was raised. The patient received an extraforaminal L5 nerve root injection with a postoperative diagnosis of bilateral lumbar radicular syndrome, left L5–S1 foraminal stenosis, and degenerative disc disease at L4–5 and L5–S1. A lumbar CT–myelogram performed on 11/21/05 was negative for thecal sac impression, disc herniation canal stenosis, or neural foraminal narrowing. On follow-up with Dr. Hochshuler, a discogram was recommended, but was denied. On 03/07/06, Dr. Hochshuler reported that the patient got temporary, but minimal relief from epidural steroid injection. Dr. Hochshuler proposed surgery to include a decompression and fusion L4–S1. The patient was seen in follow up by Dr. Hochshuler on 06/06/06 and requested epidural steroid injection and further therapy for reconditioning in order to avoid surgery. Dr. Hochshuler endorsed this strategy as reasonable. Surgical intervention was mentioned as a last resort. The patient was evaluated by Dr. John Steele on 06/23/06. His physical examination was significant for tenderness to palpation in the midline from L3 to the sacrum. Straight leg raising was negative in the seated position but positive on the left at 75 degrees. Extensor hallucis longus strength was decreased on the left. Pin wheel examination demonstrated decreased sensation in the left lower extremity involving the lateral thigh, medial leg and medial heel. Dr. Steele's diagnosis was lumbar radiculopathy and he recommended that the patient undergo a decompressive laminectomy and fusion from L4 to the sacrum. The final record is from Kathleen Kirkland, LVN indicating that the patient is scheduled for decompression and fusion from L4–5 to L5–S1.

**Questions for Review:**

Please address medical necessity of the preauthorization denial for lumbar epidural steroid injection.

**Explanation of Findings:**

Please address medical necessity of the preauthorization denial for lumbar epidural steroid

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injection.

Lumbar epidural steroid injections are not medically necessary in this patient's case.

No conclusive evidence exists to determine that spinal steroid injections give lasting improvement in patients with predominantly axial low back pain resulting from lumbar degenerative disc disease as in this patient's case. A recent prospective trial assessing the effect of epidural steroid injections and intradiscal steroid injections in patients who exhibited degenerative disc disease symptoms for more than 1 year and to determine whether patients with inflammatory end-plate changes are a unique subgroup of degenerative disc disease patients in terms of treatment response. Pain and function in patients with degenerative disc disease were prospectively assessed by an outcomes questionnaire before and after various spinal injections. Further correlation was made with end plate inflammatory (Modic Type 1) changes identified on magnetic resonance imaging (MRI). Epidural steroid injection was performed in 232 patients who were referred for treatment of degenerative disc disease, and discography with or without intradiscal steroid was performed in 171 patients who were possible spinal arthrodesis candidates. Pain and function were determined by a self-administered outcomes questionnaire that consisted of a visual analog pain scale, pain drawing, Oswestry Disability Index, use of pain medication and opinion of treatment success. Epidural steroid injection was performed in 93 patients with degenerative disc disease and inflammatory end-plate changes and in 139 patients without inflammatory end-plate changes. Patients with inflammatory end-plate changes (n=78) or without inflammatory end-plate changes (n=93), all of whom were considered fusion candidates, underwent discography with or without intradiscal steroid in a randomized fashion. Pain and function were prospectively determined by a self-administered outcomes survey (VAS pain, Oswestry Disability index [ODI], pain diagram [PD] and opinion of success) before and after the patients' injection for a 2-year follow-up period. MRI and discography results were correlated with patient outcomes scores. Epidural steroid injection was effective in improving pain and function, as assessed by outcomes scores at short-term follow-up. However, at 2 years, less than one-third had not had additional invasive treatment. Patients with inflammatory end-plate changes had greater improvement in ODI and PD scores in the first 6 months than did those patients without the end-plate changes. Intradiscal steroid injections into discs with concordant pain at the time of discography led to significant improvement in patients with inflammatory end-plate changes in all outcomes scales, but only minimal temporary improvement in patients without the end-plate changes. Disc pressure manometry at the time of discography found that discs with adjacent inflammatory end-plate changes reproduced symptoms at pressures significantly lower than those in other types of discs. The authors concluded that spinal steroid injections, both epidural steroid injection and intradiscal steroid injection, are beneficial in the short term for a small number of patients with advanced degenerative disc disease and chronic low back pain, however more than two-thirds of the study group had required additional invasive treatment. Spinal steroid injections are more effective in patients with MRI findings of discogenic

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inflammation, specifically adjacent inflammatory end-plate changes. There is no indication from the records provided that this patient is in the group manifesting discogenic inflammation. In addition, this patient had only transient improvement following an initial epidural steroid injection. The rationale for epidural steroid injections provided by the treating surgeon in this case was to potentially avoid the need for surgical intervention. One recent study called this rationale into question. The purpose of this 2005 study was to determine the effectiveness and predictors of response to lumbar epidural corticosteroid injections in patients with sciatica. The authors performed a 12-month, multicentre, double blind, randomized, placebo-controlled, parallel-group trial in four secondary pain-care clinics in the Wessex Region. Two hundred and twenty-eight patients with a clinical diagnosis of unilateral sciatica of 1–18 months' duration were randomized to either three lumbar epidural steroid injections of triamcinolone acetonide or interligamentous saline injections at intervals of 3 weeks. The main outcome measure was the Oswestry low back pain disability questionnaire (ODQ). At 3 weeks, the epidural steroid injection group demonstrated a transient benefit over the placebo group (patients achieving a 75% improvement in ODQ, 12.5 vs 3.7%; number needed to treat, 11.4). No benefit was demonstrated from 6 to 52 weeks. Epidural steroid injections did not improve physical function, hasten return to work or reduce the need for surgery. There was no benefit of repeated epidural steroid injections over single injection. No clinical predictors of response were found. At the end of the study the majority of patients still had significant pain and disability regardless of intervention. In this pragmatic study, epidural steroid injections offered transient benefit in symptoms at 3 weeks in patients with sciatica, but no sustained benefits in terms of pain, function or need for surgery. On the basis of these two well designed studies, epidural steroid injection cannot be deemed medically necessary in this patient's case.

#### **Conclusion/Decision to Not Certify:**

Lumbar epidural steroid injections are not medical necessary in this patient's case.

#### **References Used in Support of Decision:**

1. Buttermann GR. The effect of spinal steroid injections for degenerative disc disease. *Spine Journal: Official Journal of the North American Spine Society*. 4(5): 495–505, 2004 Sep–Oct.
2. Arden NK. Price C. Reading I. Stubbing J. Hazelgrove J. Dunne C. Michel M. Rogers P. Cooper C. WEST Study Group. A multicentre randomized controlled trial of epidural corticosteroid injections for sciatica: the WEST study. [Journal Article. Multicenter Study. Randomized Controlled Trial] *Rheumatology*. 44(11): 1399–406, 2005 Nov.

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The physician who provided this review is board certified by the American Board of Orthopaedic Surgery in General Orthopaedic Surgery. This reviewer is a fellow of the American Academy of Orthopedic Surgeons. This reviewer is a member of the Pediatric Orthopaedic Society of North American, the Western Orthopaedic Association and the American College of Physician Executives.

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This reviewer has been in active practice since 1994.

## Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable.

If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Chief Clerk of Proceedings/  
Appeals Clerk  
P. O. Box 17787  
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute

In accordance with Division Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 11 day of Sep/2006.

Jamie Cook

MRIOA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, and the DWC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRIOA clients. These physician reviewers

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and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by MRIOA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIOA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIOA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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Case Analyst: Jamie C ext 583

CC: Requestor and Respondent