

REDACTED PAGE

MEDICAL PROFESSIONAL REVIEW

ISSUE AT DISPUTE:

Whether the magnetic resonance imaging (MRI) of lumbar spine is/was medically necessary.

CASE SUMMARY:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated 01/22/2013.

“This 31-year-old male sustained an injury on 1/10/13. The mechanism of injury was not indicated. The diagnosis was thoracic or lumbosacral neuritis or radiculitis. On 1/13/13, Dr. [REDACTED] indicated complaints of low back pain that was sharp and moderate. The patient was feeling better until he started doing exercises off the range of motion sheet. There was tenderness and spasms of the thoracolumbar spine/paravertebral musculature. There was restricted range of motion. Waddell’s sign was positive. The diagnosis was radiculopathy of lumbar, sciatica, and lumbar sprain/strain. Treatment plan included physical therapy. On 1/16/13, Dr. [REDACTED] indicated continued low back pain. There was tenderness/spasm of the thoracolumbar spine. Waddell’s was 2/5 with new finding. There was no straight leg raising. Treatment plan was to change medication and consider an MRI at next visit.”

DOCUMENTS REVIEWED FOR DETERMINATION:

1. Application for IMR
2. Utilization Review (completed by [REDACTED])
3. Employee’s Medical Records from [REDACTED] (dated 1/10/13 through 2/6/13)

MEDICAL TREATMENT GUIDELINE(S) RELIED UPON BY PROFESSIONAL REVIEWER AND WHY:

The claims administrator cited American College of Occupational and Environmental Medicine (ACOEM), 3rd Addition, 2004 Chapter 12 (pages 303-304). The provider did not indicate what guideline(s) s/he applied. The professional reviewer relied upon the American College of Radiology (ACR) guidelines for acute low back pain and appropriateness criteria low back pain with non surgical presentation. (www.acr.org. Date of origin 1996; last reviewed 2011). The professional reviewer deemed the ACR guidelines had a greater preponderance of evidence, were more appropriate, and had greater specificity to the specific clinical circumstance of the employee.

**RATIONALE FOR WHY THE REQUESTED TREATMENT/SERVICE IS/WAS NOT
MEDICALLY NECESSARY:**

Patient is 31 years of age and had injury of unknown mechanism resulting in low back pain without neurological deficit. Plain films showed no fracture. There are no red flags indicating immediate MRI evaluation. A conservative course of therapy up to 6 weeks including non-steroidal anti-inflammatory drugs and physical therapy are indicated prior to moving to MRI particularly in light of no neurological deficit and no fracture on plain films.

MEDICAL REVIEWER QUALIFICATIONS:

The professional reviewer is an M.D. with board certification in Radiology. The reviewer is licensed in CA. The reviewer is knowledgeable in the treatment of the employee's medical condition, knowledgeable about the proposed treatment, and familiar with guidelines and protocols in the area of the treatment under review. The reviewer holds a current certification by a recognized American medical specialty board in the area or areas appropriate to the treatment under review and has no history of disciplinary action or sanctions against his or her license.

The determination of MAXIMUS and our professional reviewer is deemed to be the final determination of the administrative director, DWC.

However, in accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the aggrieved employee or the aggrieved employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely;

IMR Manager