MAXIMUS Federal Services

Case Number:	CM15-0098075		
Date Assigned:	05/29/2015	Date of Injury:	08/20/2011
Decision Date:	06/26/2015	UR Denial Date:	04/21/2015
Priority:	Standard	Application Received:	05/21/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Iowa, Illinois, Hawaii
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 55 year old male, who sustained an industrial injury on 08/20/2011. He has reported subsequent headaches and low back pain radiating to the bilateral lower extremities and was diagnosed with closed head injury and lumbar radiculopathy. Treatment to date has included oral pain medication and an epidural injection. In a progress note dated 04/15/2015, the injured worker complained of muscle spasm of the abdominal wall and paraspinal muscles. No objective findings were documented. A request for authorization of electromyogram/nerve conduction study of the bilateral upper and lower extremities, anti-GAD antibody and Baclofen was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

EMG/NCV of bilateral upper and lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), ODG-TWC Guidelines, Chapter: Forearm, Wrist & Hand, pp 270; Official Disability Guidelines (ODG), Low Back, pp 303-305.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 260-262, 303, 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Electrodiagnostic testing (EMG/NCS).

Decision rationale: ACOEM States "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful." ODG states "Recommended needle EMG or NCS, depending on indications. Surface EMG is not recommended. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II (causalgia), when testing is performed by appropriately trained neurologists or physical medicine and rehabilitation physicians (improperly performed testing by other providers often gives inconclusive results). As CRPS II occurs after partial injury to a nerve, the diagnosis of the initial nerve injury can be made by electrodiagnostic studies." ODG further clarifies "NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." Additionally, ACOEM states "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." ODG states in the Low Back Chapter and Neck Chapter, "NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. See also Monofilament testing." The treating physician does not document evidence of radiculopathy, muscle atrophy, and abnormal neurologic finings. The treating physician does document a negative Tinel's sign. The treating physician has not met the above ACOEM and ODG criteria for an EMG of the upper extremities. As such, the request for EMG/NCV of bilateral upper and lower extremities is not medically necessary.

Anti GAD antibody: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Library of Medicine.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Glutamic acid decarboxylase autoantibodies and neurological disorders. Review article Vianello M, et al. Neurol Sci. 2002.PMID 12536283 [PubMed - indexed for MEDLINE]http://www.ncbi.nlm.nih.gov/m/pubmed/12536283/.

Decision rationale: MTUS and ODG are silent in regards to AntiGAD antibody testing. Pub Med states "Glutamic acid decarboxylase (GAD) is the enzyme that catalyses the production of

GABA, a major neurotransmitter of the central nervous system. Antibodies to GAD (GAD-Ab) were first recognized in a patient affected by stiff-person syndrome; subsequently they were reported in a large number of cases with type 1 diabetes. Recently GAD-Ab have been described in a number of patients affected by chronic cerebellar ataxia, drug-resistant epilepsy and myoclonus. These cases usually harbor other autoantibodies or are affected by organ-specific autoimmune diseases. The role of GAD-Ab is still unclear; the lack of experimental models makes it difficult to investigate their potential pathogenetic role. However two mechanisms have been suggested: the reduction by GAD-Ab of GABA synthesis in nerve terminals or the interference with exocytosis of GABA." The medical documentation provided indicate this patient has had some sort of subacute infarct to the left cerebellum. The etiology behind this infarct is unknown. The request for Anti GAD antibody testing would be appropriate to help with causation and diagnosis of this patient's ongoing symptoms. As such, the request for Anti GAD antibody is medically necessary.

Baclofen 10mg #20: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63-64.

Decision rationale: Baclofen is classified as a muscle relaxant. MTUS states "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement." Additionally, MTUS states "Baclofen (Lioresal, generic available): The mechanism of action is blockade of the pre- and post-synaptic GABAB receptors. It is recommended orally for the treatment of spasticity and muscle spasm related to multiple sclerosis and spinal cord injuries. Baclofen has been noted to have benefits for treating lancinating, paroxysmal neuropathic pain (trigeminal neuralgia, non-FDA approved). (ICSI, 2007)." The treating physician has not provided documentation of muscle spasms related to multiple sclerosis or spinal cord injuries. Additionally, the treating physician has not provided documentation of trials and failures of first line therapies. As such the request for Baclofen 10mg #20 is not medically necessary.