MAXIMUS Federal Services

Case Number:	CM14-0193779		
Date Assigned:	12/01/2014	Date of Injury:	01/14/2009
Decision Date:	01/14/2015	UR Denial Date:	10/21/2014
Priority:	Standard	Application Received:	11/19/2014

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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is an injured worker with low back complaints. The patient sustained an industrial injury on 1/14/09. The mechanism of injury was a motor vehicle accident in which she was rear ended, wearing a seatbelt, by the same car multiple times as the other driver stomped on the accelerator instead of the brake. The diagnoses were discogenic sciatic radiculopathy, mechanical low back pain syndrome, loss of motion and abnormal posture. The pain management consultation report dated 6/4/14 documented normal gait and 5/5 motor strength of the lower extremities. Electromyography (EMG) and Nerve conduction velocity (NCV) dated 7/8/14 demonstrated normal electrodiagnostic study of bilateral lower limbs. There is no electrodiagnostic evidence of peroneal nerve entrapment, lumbar radiculopathy, or generalized peripheral neuropathy. All nerve conductions studies were within normal limits. All examined muscles showed no evidence of electrical instability. The primary treating physician's progress report dated 10/7/14 indicated that the patient had low back pain and bilateral leg numbness and cramping. She had seen a neurologist and EMG electromyography as well as neuropsychological memory assessment testing was recommended. The patient notes sharply increased low back pain and right more so than left lower extremity pain and cramping. The patient notes that a constant sense of pressure cramping and numbness to the lower extremities and feet has sharply reduced her functional capacity and most notably reduced her capacity to fall asleep and stay asleep. She states that she Is more exhausted than ever by virtue of the increased interference with her capacity for sleeping. Therapeutic exercises and activities modifications have failed to induce any meaningful improvement. This patient continues to have significant memory problems. Physical examination was documented. On the back physical examination, the patient had spasm, decreased range of motion, hypertonicity, weakness, positive straight leg raise, hypoesthesia, motor weakness and is areflexia bilaterally. There is sharp pain to palpation in the

bilateral sciatic notches. There is significant hypertonicity in the gluteal muscle groups bilaterally right more so than left hamstring groups and right more so than left calf musculature. This patient cannot tandem toe walk by virtue of weakness to plantar flexion on the right more so than the left. Tandem heel walking is associated with increased low back and sciatic distribution pain and therefore this patient stops the attempt at this procedure. Dorsiflexion at the ankles appears to be well-maintained. The calf test for microcirculation assessment was conducted demonstrating a significant reduction of microcirculation through the calf musculature. Straight leg raise testing is positive. Neurological testing demonstrates areflexia bilaterally at the ankle jerks, one plus at the patellar jerks bilaterally. There is hypoesthesia in the L5 and S1 distributions on the right more so than the left. Motor weakness as noted in the L5 and S1 distributions. The diagnoses were discogenic sciatic radiculopathy, mechanical low back pain syndrome, loss of motion segment integrity lumbar spine, and abnormal posture flexion antalgia. Treatment plan was documented. Niacinamide and mass balance orthotics both feet were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Mass Balance Orthotics both feet: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 12th Edition (web), 2014, Low Back, Shoe

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints, Chapter 12 Low Back Complaints Page(s): 308; 370-372, 376-377.

Decision rationale: The Medical Treatment Utilization Schedule (MTUS) addresses foot orthotics. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 14 Ankle and Foot Complaints (pages 370-372) states that rigid orthotics is treatment options for plantar fasciitis and metatarsalgia. Table 14-6 Summary of Recommendations for Evaluating and Managing Ankle and Foot Complaints (page 376) recommends for appropriate diagnoses, rigid orthotics are recommended. ACOEM Chapter 12 Low Back Complaints Table 12-8 Summary of Recommendations for Evaluating and Managing Low Back Complaints (Page 308) indicates that shoe lifts are not recommended. The pain management consultation report dated 6/4/14 documented normal gait and 5/5 motor strength of the lower extremities. Electromyography (EMG) and nerve conduction velocity (NCV) dated 7/8/14 demonstrated normal electrodiagnostic study of bilateral lower limbs. The primary treating physician's progress report dated 10/7/14 does not document a foot diagnosis. The request for foot orthotics is not supported by MTUS and ACOEM guidelines. Therefore, the request for Mass Balance Orthotics both feetis not medically necessary.

Niacinamide powder 70 MG 1 container: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG),

Treatment Index, 12th Edition (web), 2014, Pain, Medical Foods and UpToDate, online version 19.2, Niacinamide

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic) Vitamin B, Niacinamide http://www.nlm.nih.gov/medlineplus/druginfo/natural/924.html

Decision rationale: The Medical Treatment Utilization Schedule (MTUS) does not address Niacinamide. Niacinamide is a form of Vitamin B3. Official Disability Guidelines (ODG) indicates that Vitamin B is not recommended for the treatment of chronic pain.Electromyography (EMG) and nerve conduction velocity (NCV) dated 7/8/14 demonstrated normal electrodiagnostic study of bilateral lower limbs. There is no electrodiagnostic evidence of peroneal nerve entrapment, lumbar radiculopathy, or generalized peripheral neuropathy. All nerve conductions studies were within normal limits. All examined muscles showed no evidence of electrical instability. The ODG guidelines do not support the request for Niacinamide.Therefore, the request for Niacinamide powder 70 MG 1 container is not medically necessary.