

<b>Case Number:</b>	CM14-0012752		
<b>Date Assigned:</b>	06/16/2014	<b>Date of Injury:</b>	04/27/2012
<b>Decision Date:</b>	07/29/2014	<b>UR Denial Date:</b>	01/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/31/2014

### 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 Orthopedic Surgery has a subspecialty 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:

This 34-year-old female x-ray technician sustained an industrial injury on 4/27/12, due to repetitive work activities. The 7/16/12 left lower extremity electrodiagnostic study was reported as normal. The patient underwent left knee diagnostic arthroscopy surgery on 9/14/12. The 2/28/13 lumbar MRI impression documented a mild disc bulge with annular fissure at L3/4 without significant canal or foraminal compromise, and without nerve root impingement. The 12/17/13 treating physician report cited follow-up for low back, left knee and left lower extremity complaints. There was persistent numbness along the left plantar medial and dorsal medial foot. An L3/4 epidural steroid injection provided no significant relief of her symptoms. A right sacroiliac cortisone injection had several days of excellent relief of her low back pain and no relief of her left lower extremity symptoms. She saw a spine surgeon who recommended a course of intensive physical therapy prior to considering a sacroiliac joint fusion. Physical exam showed moderate right sacroiliac joint tenderness, no midline tenderness, and negative straight leg raise. There was a positive Tinel's at the peroneal nerve on the lateral knee and deep pressure caused increased paresthesias and numbness. Left knee exam documented no medial joint line tenderness, 0-140 degrees flexion, and no varus/valgus laxity. The impression documented severe right sacroiliitis and left foot numbness consistent with probable combined nerve peroneal nerve entrapment at the knee, distal to the fibular head, and left lumbar radiculitis. The treatment plan recommended additional follow-up visits and treatment with the orthopedic spine surgeon to manage her low back condition. A request for left knee peroneal nerve decompression was recommended as her symptoms came on within a few days after her left knee surgery. The 1/3/14 utilization review denied the requests for left knee peroneal nerve decompression and follow-up visits and treatment with an orthopedic spine surgeon. The surgery was denied based on lack of electrodiagnostic evidence of peripheral neuropathy. The referral to a spine surgeon

was denied based on absence of a surgical condition. The 2/5/14 treating physician report cited persistent plantar foot numbness and hypersensitivity. Left lower extremity exam documented medial joint line tenderness, negative for Tinel's over the fibular head, positive for Tinel's along the tarsal tunnel. There was increased paresthesias and numbness with direct compression of the tarsal tunnel. An EMG/nerve conduction study was recommended isolated to the left foot to rule-out tarsal tunnel syndrome. The 2/2/14 left lower extremity electrodiagnostic study impression documented a normal study with no evidence for left leg mononeuropathy or polyneuropathy.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Left knee peroneal nerve decompression: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 288.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints Page(s): 305-306, 343-347.

**Decision rationale:** The American College of Occupational and Environmental Medicine (ACOEM) guidelines state that there should be clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long-term from a surgical repair prior to surgical consideration. Guideline criteria have not been met. There is no electrodiagnostic evidence of left leg mononeuropathy or polyneuropathy. In the absence of a clear surgical indication, this request for left knee peroneal nerve decompression is not medically necessary.

**Follow up visits and treatment with the Orthopedic Spine Surgeon: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines, 2nd Edition.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines, 2nd Edition, (2004) Independent Medical Examinations and Consultations, page(s) 127.

**Decision rationale:** The California MTUS guidelines support referral to a specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for treatment of a patient. In this case, the request is for follow-up visits and treatment with an orthopedic spine surgeon who is managing the patient for a diagnosis of sacroiliitis. A follow-up visit for treatment assessment and additional recommendations is reasonable, and medical necessity of multiple visits is not established. A blanket request for future unknown treatment is not consistent with guidelines, as

medical necessity cannot be established. Therefore, this request for follow up visits and treatment with an orthopedic spine surgeon is not medically necessary.