

<b>Case Number:</b>	CM14-0049757		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	08/07/2000
<b>Decision Date:</b>	12/25/2014	<b>UR Denial Date:</b>	03/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/17/2014

### 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 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:

This 54-year-old male sustained an industrial injury on 8/7/00. Low back injury occurred when he picked up a case of vinegar and his back popped with severe pain. Past surgical history was positive for L5/S1 disc replacement surgery on 2/14/08, right partial knee arthroplasty in 2009, left total knee arthroplasty on 8/24/11, lower extremity complex regional pain syndrome (right greater than left), and status post spinal cord stimulator implantation in Marcy 2012 with post-op wound infection April 2012, lead explantation May 2012, and wound dehiscence/necrotic tissue August 2012. Past medical history was positive for fibromyalgia. The 9/16/13 podiatry report cited grade 7-10/10 lower extremity pain with associated burning, electric-like shock, tightness, numbness, pricking, and tingling sensation radiating distally from the knees to the toes, right worse than left. The patient waked with a severe limp and used a cane. There was severe bilateral foot pain, right greater than left, diagnosed as fasciitis. Pain was mostly at the knee, at the common peroneal nerve, distal and lateral to the knee. Physical exam documented heel pain associated with the sural and posterior tibial nerves. There was positive Tinel's at the soleal sling, and posterior tibial, plantar medial and lateral, common peroneal, superficial peroneal, deep peroneal, and sural nerves. The diagnosis was trauma to the peripheral nerves bilaterally, trauma to the lower back, plantar fasciitis, and chronic nerve pain. The treating podiatrist stated that the sural nerve was damaged and must be denervated to resolve the pain. The treatment plan recommended diagnostic nerve blocks to identify if the tibial nerve was as symptomatic as the peroneal nerve. Surgery was requested to include decompression of the common peroneal, superficial peroneal, deep peroneal, posterior tibial, lateral plantar and medial plantar nerves with fasciotomy of the leg. The 10/9/13 podiatry report indicated that pain was unchanged. Physical exam was unchanged. The patient presented to follow-up evaluation. The treatment plan recommended pre-operative diagnostic nerve blocks to the left foot x 4 on the next visit. The

12/30/13 orthopedic report documented low back, bilateral knee and right ankle pain. Physical exam documented right knee range of motion 8-106 degrees with positive McMurray test on the right and positive abduction and adduction stress tests bilaterally. The diagnosis included bilateral tarsal tunnel syndrome, status post bilateral knee surgery. Authorization was pending for a right total knee replacement. The 3/13/14 utilization review denied the request for right knee decompression surgery as there was no evidence of electrodiagnostic and there was a history of failed back surgery and fibromyalgia that complicated the lower extremity diagnosis.

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

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

#### **RIGHT KNEE DECOMPRESSION OF THE COMMON PERONEAL NERVE, SUPERFICIAL PERONEAL NERVE, DEEP, POSTERIOR, TIBIAL, LATERAL PLANTAR AND MEDIAL PLANTAR NERVE WITH FASCIOTOMY OF THE LEG:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 374. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle and Foot, Surgery for peroneal nerve dysfunction, Surgery for tarsal tunnel syndrome

**Decision rationale:** The California MTUS guidelines indicate that surgical consideration may be indicated for patients with clear clinical and imaging evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. The Official Disability Guidelines recommend surgery for tarsal tunnel syndrome after conservative treatment for at least one month. Patients with clinical findings and positive electrodiagnostic studies of tarsal tunnel syndrome warrant surgery when significant symptoms do not respond to conservative management. Surgery for peroneal nerve dysfunction is recommended as an option when symptoms persist for longer than 3 months despite conservative measures. Guideline criteria have not been met. There is no current exam evidence of peroneal nerve dysfunction relative to muscle weakness or foot drop. There is no clear imaging or electrodiagnostic studies to support the medical necessity of the requested surgery. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.