

<b>Case Number:</b>	CM15-0221627		
<b>Date Assigned:</b>	11/17/2015	<b>Date of Injury:</b>	02/28/2008
<b>Decision Date:</b>	12/30/2015	<b>UR Denial Date:</b>	11/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/11/2015

### 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: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 injured worker is a 54-year-old male who sustained an industrial injury on 2/28/08. Injury occurred when an oil rig elevator came down on his leg completely amputating the left lower leg. He underwent left below the knee amputation (BKA) surgery in 2008 and multiple surgeries for hardware removal, revision of the stump, and transposition of one of the peroneal nerves on 10/5/12. The 5/13/15 left tibia and fibula x-rays documented status post BKA, with no periosteal reaction or fractures. The 6/10/15 left knee MRI impression documented status post BKA with fusion of the proximal tibia fibular joint and fusion of the distal tibiofibular stumps. There was no adventitial bursal formation. There was a mild increase in the diameter of the tibial nerve stump with no definite neuroma identified. The 6/12/15 orthopedic consult report documented persistent symptoms in the stump following the nerve transposition. He complained of constant grade 7/10 pain radiating up into the knee with any direct pressure on the distal/lateral stump. He had returned to work in a mostly sedentary role but was unable to do more active duty due to stump pain. Conservative treatment had included multiple injections into the stump to try and alleviate the stump pain without even brief improvement. He had formerly being taking one Vicodin a day, but currently he was taking 4-5 a day. He had tried multiple nerve suppression medications but had mood and memory side effects. He was using a wheelchair at home and was limited to 10-15 minutes of walking in his prosthesis due to pain. Physical exam documented point tenderness at the distal stump causing radiating pain. There was tenderness over the bony bridge between the tibia and fibula but this was not the main area of symptom. A discrete nodule or mass could not be palpated. The orthopedist felt that further imaging was warranted and

referral to pain management as she was not certain that symptoms were entirely structural given the failure to respond even slightly to the injections. The 10/26/15 orthopedic specialist report cited ongoing neuroma pain at the tip of the BKA. He was not improving and symptoms were worse with walking. Pain seemed to shoot to the medial dorsal foot sometimes. He was taking 4-6 tabs of Norco 10/325 mg a day and Lyrica. Physical exam documented well-healed wounds and a tender-sensitive area over the most distal, slightly posterior, central area of the BKA stump. There was supple tissue and a positive Tinel's over this area. The diagnosis was traumatic amputation of the left leg with severe neuroma pain. The symptoms were more posterior and could be from the sural nerve. Authorization was requested for excision neuroma and muscle advancement of the left BKA. The 11/5/15 utilization review non-certified the request for left BKA neuroma excision and muscle advancement as there was a second opinion recommending against further stump surgery. A peer-to-peer discussion was documented with agreement to perform a diagnostic anesthetic block prior to any neuroma surgery to potentially prove the presence of the neuroma.

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

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

**Excision neuroma, left BKA (below knee amputation): 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), Knee Chapter, Nerve excision (following TKA).

**MAXIMUS guideline:** Decision based on MTUS Knee Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg: Amputation; Nerve excision (following TKA).

**Decision rationale:** The California MTUS state that surgical consideration may be indicated for patients who have activity limitation for more than one month and failure of exercise programs to increase range of motion and strength of the musculature around the knee. The Official Disability Guidelines generally recommend excision for neuromas for total knee arthroplasty (TKA) patients, but not solely for incisional pain. Consideration for this procedure requires pain of at least a 1-year duration, failure of conservative management, pain localization at a Tinel's point, and at least a 5-point reduction of pain on a visual analog scale after nerve blockade with 1% lidocaine. Guideline criteria have not been met. This injured worker presents status post below knee amputation and nerve transposition with persistent nerve pain at the distal stump. Imaging demonstrated a mild increase in the diameter of the tibial nerve stump with no definite neuroma identified. He had point tenderness and a positive Tinel's over the area, but had failed to respond to local injections. There was no documentation of a positive nerve blockade. Therefore, this request is not medically necessary at this time.

**Muscle advancement, left BKA (below knee amputation): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Knee Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg: Amputation; Nerve excision (following TKA).

**Decision rationale:** As the surgical request for neuroma excision is not supported, this request is not medically necessary.