

Case Number:	CM14-0117557		
Date Assigned:	08/06/2014	Date of Injury:	07/13/2004
Decision Date:	10/14/2014	UR Denial Date:	06/27/2014
Priority:	Standard	Application Received:	07/25/2014

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 Alaska and Texas. 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 injured worker is a 59-year-old male who reported an injury on 07/13/2004 due to an unknown mechanism. Diagnoses was status post left tarsal tunnel release, persistent numbness and irritability. Past treatments were not reported. Diagnostic studies were not reported. Surgical history was left foot arthroscopy, synovectomy, Brostrom repair, peroneus brevis repair. The injured worker had ongoing pain and underwent a left tarsal tunnel release. Physical examination on 03/19/2014 revealed complaints of persistent numbness of the left foot. The injured worker reported that his foot is unstable and he feels that it is getting worse. Examination revealed a positive Tinel's sign with a posterior medial ankle scar. There was a decrease in sensation, plantar aspect of the foot, but symmetrical, medial, and plantar nerves, in addition to calcaneal branch distribution where the injured worker reported he could barely feel any sensation. There was smooth range of motion of the ankle, subtalar, and MT joints. There was a negative drawer test. Medications were not reported. Treatment plan was for the injured worker to try a topical compound gel that included ketoprofen 10%, lidocaine 5%, Neurontin 10%. Treatment plan was to refer the injured worker for a microscopic neurolysis with vein or neural tube grafting. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Referral to [REDACTED], **Ortho:** Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Microscopic Neurolysis by Stevanovic: 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): 374-375. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle and Foot Surgery, Surgery for Peroneal Nerve Dysfunction [http://www.orthopaedicsandtraumajournal.co.uk/article/S1877-1327\(09\)00149-3/abstrac](http://www.orthopaedicsandtraumajournal.co.uk/article/S1877-1327(09)00149-3/abstrac), Volume 23, Issue 6, pages 404-411, December 2009.

Decision rationale: According to the Orthopaedics and Trauma Magazine, any of the 5 nerves supplying the foot and ankle (tibial, superficial, and deep peroneal, sural, saphenous) can suffer compression neuropathy. The diagnosis is usually made clinically, supported by imaging and electrodiagnostic studies. Treatment is conservative or surgical. The California ACOEM Guidelines do not address directly microscopic neurolysis. The medical guidelines state for surgical considerations, a referral for surgical consultation may be indicated for patients who have activity limitation for more than 1 month without signs of functional improvement, or they have a failure of exercise programs to increase range of motion and strength of the musculature around the ankle and foot; 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 state common peroneal nerve dysfunction is damage to the peroneal nerve leading to loss of movement or sensation in the foot and leg, including foot drop. The first line in treatment is avoiding activity that makes the pain worse, especially prolonged squatting. Steroid injections near the peroneal nerve at the fibular head help some patients, but reoccurrences are common. If the patient has a foot drop, then an ankle splint may be prescribed. In general, when symptoms persist for longer than 3 months despite these conservative measures, surgery is an option. Decompression of the peroneal nerve at the fibular head is performed in day surgery with the skin numbed with lidocaine and the patient sedated. Using a 3 inch incision, the procedure takes about 30 to 40 minutes. During surgery the skin is incised, and then the peroneal nerve is identified under the skin and followed to where it is compressed by fascia and muscle near the fibular head. All compression points are released and it is made certain the fibula itself is not compressing the nerve. It is unknown exactly, what the diagnosis is for the injured worker. The provider did not submit diagnostic studies. Conservative care was not reported. The clinical documentation submitted for review does not provide evidence that the injured worker needs microscopic neurolysis. Therefore, this request is not medically necessary.