

<b>Case Number:</b>	CM15-0095019		
<b>Date Assigned:</b>	05/21/2015	<b>Date of Injury:</b>	04/22/2013
<b>Decision Date:</b>	06/24/2015	<b>UR Denial Date:</b>	05/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/18/2015

### 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: California, Indiana, Oregon  
 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 is a 52 year old female with an April 22, 2013 date of injury. A progress note dated April 30, 2015 documents subjective findings (severe pain in the left knee with increasing weakness; difficulty with ambulation; complete resolution of lower back pain and all radicular symptoms; pain in the left leg rated at a level of 8/10; constant pain in the cervical spine with radiation to the upper extremities and associated headaches; pain that is rated at a level of 8/10; intermittent pain in the right hip rated at a level of 6/10), objective findings (antalgic gait; slight discomfort over the left fibular head with positive Tinel's; extension of symptoms into the left foot and ankle noted with weakness in dorsiflexors and EHL; severe hypersensitivity and hot and cold intolerance; definite pins and needles sensation; findings consistent with left peroneal neuropathy; visible atrophy of the left calf; palpable paravertebral muscle tenderness with spasm in the cervical spine; positive axial loading compression test; positive Spurling's maneuver; limited range of motion of the cervical spine with pain; findings consistent with double crush syndrome; positive Tinel's, consistent with carpal tunnel syndrome; increasing tenderness on the internal and external rotation in the right hip; painful range of motion), and current diagnoses (cervical discopathy/cervicalgia; carpal tunnel/double crush syndrome; left peroneal neuropathy; rule out internal derangement of the right hip). Treatments to date have included lumbar spine fusion, medications, imaging studies, and electromyogram/nerve conduction velocity study of the lower extremities (April 28, 2015; showed unobtainable left peroneal motor study indicating a superimposed entrapment on an ongoing active L5 radiculopathy). The treating physician

documented a plan of care that included left posterior tibial/peroneal nerve decompression and associated services.

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

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

**Left posterior tibial/ peroneal nerve decompression:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Ramanan and Chandran KN. Source Department of Neurosurgery.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Humphreys et al., Patient Outcome after Common Peroneal Nerve Decompression., Journal of Neurosurgery. 2007 vol1107:314-318.

**Decision rationale:** CA MTUS/ACOEM and ODG are silent on peroneal nerve decompression. Alternate reference of Humphreys et al., Patient Outcome after Common Peroneal Nerve Decompression., Journal of Neurosurgery. 2007 vol1107:314-318 is used. Peroneal nerve decompression can restore strength and sensation in patients demonstrating clinical and EMG findings consistent with entrapment near the fibular head. In this case the request is for decompression of the posterior tibial nerve as well which is documented as normal on the EMG of 4/28/15. Therefore the request is not medically necessary.

**Associated surgical service: Crutches:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg Procedure Summary online version.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Humphreys et al., Patient Outcome after Common Peroneal Nerve Decompression., Journal of Neurosurgery. 2007 vol1107:314-318.

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

**Associated surgical service: Medical clearance:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Humphreys et al., Patient Outcome after Common Peroneal Nerve Decompression., Journal of Neurosurgery. 2007 vol1107:314-318.

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