

Case Number:	CM14-0030460		
Date Assigned:	06/20/2014	Date of Injury:	07/31/1998
Decision Date:	08/06/2014	UR Denial Date:	02/12/2014
Priority:	Standard	Application Received:	03/10/2014

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 Pennsylvania. 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 claimant is a 65-year-old female who was injured in a slip and fall while working as an inspector on 7/31/98. The records provided for review document the claimant's past surgical history to include a lumbar fusion in 1989, anterocervical discectomy and fusion in 2000 and 2006, bilateral carpal tunnel releases in 2006, and right shoulder open surgeries in 2004 and 2005. The claimant's current working diagnosis is right posttraumatic thoracic outlet syndrome and cervical radiculopathy. The office note dated 2/13/14 noted complaints of severe pain in the right side of the neck that radiated into the right hand, associated with weakness and numbness. Elevation of the right arm caused the claimant to have an increased weakness and numbness sensation in her right hand. She also offered similar type of complaints in the left arm attributed to use of non-dominant left arm and hand. On examination she had 4/5 strength of the right finger flexors and intrinsic muscle of the right hand, sensory loss to light touch, pinprick, and two-point discrimination of the right hand and fingers, and deep tendon reflexes were noted to be symmetric. The claimant had severe muscle spasm in the posterocervical musculature, especially in the right trapezius muscle and a positive Spurling's. She had a positive Tinel's in the region of the right brachial plexus. The Adson and Roos testing including the brachial plexus stress testing were positive. Elevation of the right arm caused increased weakness and numbness sensation in the right arm and extension in lateral rotation of the cervical spine caused increased neck pain. The report documents that a soft tissue ultrasound of the brachial plexus bilaterally showed severe fibrosis of the scalene anterior muscle causing compression of the right brachial plexus. Adhesion extended to the right middle and lower trunks of the right brachial plexus. There is associated edema of the right pectoralis minor muscle. The Doppler test demonstrated significant reduction of the blood flow within the right subclavian artery with minimal elevation of the right arm. Ultrasound of the right shoulder demonstrated that her rotator cuff tendons were intact, that

she had tendinitis of the supraspinatus tendons as well as fibrosis adhesions within the right shoulder. Cervical spine x-rays with flexion, extension views from 2/11/14 showed status post ACDF at the C4-5 level with bony fusion demonstrated. There was a loss of intervertebral disc height seen at the C3-4 level and there was a bridging osteophyte seen at the C2-3 level. There was straightening of the normal cervical spinal lordosis with no prevertebral soft tissue abnormalities. In flexion, extension, there was no evidence for spondylosis or spondylolisthesis. An EMG/nerve conduction study from 2/13/14 showed normal peripheral nerve study for neuropathy and entrapment. EMG pattern demonstrated mixed results with ongoing denervation, which may be due to an upper and partial posterior trunk/cord brachial plexopathy and/or cervical disc disease. Primary right shoulder pathology could not be studied with the testing. An MRI of the cervical spine demonstrated a C3-4 and C4-5 3 to 3.5 mm broad-based disc protrusion, centrally located producing compression of the spinal cord with mild-2-moderate central canal stenosis. At C6-7, there is a slight central cord compression with a 3 mm disc herniation and at C5-6 showed a fusion and at C2-3 there was a 2 mm disc protrusion flattening at the thecal sac. Conservative care to date includes Nucynta, subacromial injection of the left shoulder provided on 2/14/14, Lyrica, and Cymbalta.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pre-op Diagnostic Studies (unknown what studies requested): Upheld

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

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.

Right Scalenectomy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment Workers Compensation, online edition. Shoulder Chapter, scalenectomy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-212. Decision based on Non-MTUS Citation Official Disability Guidelines.

Decision rationale: The guidelines recommend a minimum of three months of physical therapy leading to a home exercise program prior to consideration of surgery. In addition, there should be documented diagnostic testing to include an abnormal arteriogram, or venogram, or electrodiagnostic studies showing specifically reduced amplitude of the median motor response, reduced amplitude of the ulnar sensory response, or denervation in muscles innervated by the lower trunk of the brachial plexus. Therefore, the request is not medically necessary.

