

Case Number:	CM14-0076983		
Date Assigned:	07/18/2014	Date of Injury:	03/16/2009
Decision Date:	09/17/2014	UR Denial Date:	05/17/2014
Priority:	Standard	Application Received:	05/27/2014

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 Vascular Surgery, has a subspecialty in Vascular Surgery Board of American Board of 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:

The patient is a 44 year old male who reported an industrial injury on 3/16/2009, resulting from slip on fall. He also developed neck, bilateral knee, and bilateral wrist complaints. He underwent right shoulder arthroscopic SLAP repair and subacromial decompression on 5/26/2010 and revision arthroscopy on 6/23/2011. Also status post right CTR on 11/17/2011. An EMG/NCV of the bilateral upper extremities performed on 11/26/2013 reveals evidence of mild median sensory prolongation through the right carpal tunnel and evidence of moderate median nerve prolongation through the left carpal tunnel and mild to moderate ulnar nerve prolongation over the left across the elbow. No evidence of cervical radiculopathy or peripheral neuropathy. The 11/9/2012 MRI of the right brachial plexus reveals a normal right brachial plexus. According to the PR-2 dated 6/4/2014, the patient continues complaints of neck pain radiating to the bilateral arms with numbness and right shoulder pain rated 8/10, and bilateral wrist pain with numbness and tingling and low back pain with numbness and tingling rated 7/10. Objective findings include positive apprehension and hawkin's signs of the right shoulder, and right shoulder motion of flexion 110/180, extension 35/50, abduction 160/180, adduction 30/50, internal and external rotation 50/90. Diagnoses are cervical IVD with displacement without myelopathy, status/post arthroscopic repair with residuals of right shoulder, and right upper extremity radiculopathy. According to the 7/24/2014 office visit report, the patient was seen for follow-up regarding is complaint of neck pain, arm pain and tingling numbness. He has cervical DDD and has not improved. Examination reveals mild right grip weakness, decreased right C5, C6 and left C6 sensation. Diagnosis is cervical radiculopathy. Recommendation is cervical MRI. Remains off work. The patient's current medications are Robaxin and Norco.

IMR ISSUES, DECISIONS AND RATIONALES

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

(1) **Right Scaleneotomy:** Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder (Acute & Chronic), Indications for Surgery; Washington, 2002; Wickizer, 2004; Baltopoulos, 2008; Vemuri, 2013.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211-212. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Scaleneotomy see Surgery for Thoracic Outlet Syndrome (TOS).

Decision rationale: Although the CA MTUS ACOEM guidelines state most patients with acute thoracic outlet compression symptoms will respond to a conservative program of global shoulder strengthening (with specific exercises) and ergonomic changes, this man has chronic pain syndrome with symptoms and signs not consistent with neurogenic TOS. I agree that surgical decompression which would consist of anterior scaleneotomy, 1st rib resection, and brachial plexus neurolysis is sometimes indicated in patients with upper extremity pain, progressive weakness, atrophy, and neurologic dysfunction. I agree that a confirmatory response to electromyography (EMG)-guided scalene block, and MRI of the cervical spine and shoulder may be useful in the evaluation of this patient, and is advisable prior to considering surgical intervention. The medical records fail to establish the patient has Neurogenic thoracic outlet syndrome. There is no diagnostic evidence of ulnar or unilateral C7-C8 nerve root neuropathy. The EMG/NCV revealed mild median neuropathy consistent with residual CTS on the right. The MRI of the right brachial plexus was normal. There are no corroborate subjective findings nor objective clinical findings to support neurogenic thoracic outlet syndrome is present in this case. In the absence of a high likelihood of neurogenic TOS, the patient is not a candidate for anterior scaleneotomy alone. Therefore the request is not medically necessary.