

Case Number:	CM15-0106496		
Date Assigned:	06/10/2015	Date of Injury:	06/25/2014
Decision Date:	07/13/2015	UR Denial Date:	05/05/2015
Priority:	Standard	Application Received:	06/02/2015

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:

The injured worker is a 56-year-old female who sustained an industrial injury on 6/25/14. Injury occurred when she opening a refrigerator door and it dropped to the right puling on her left arm. Past surgical history was positive for a parotid tumor dissection on the left side of her neck years ago. The 7/29/14 cervical spine MRI demonstrated minimal degenerative changes with mild facet arthropathy at left C4/5 and C5/6. The 9/20/14 left shoulder MRI impression documented a focal tear of the anterior glenoid labrum and associated paralabral cyst extending into the subcoracoid recess. There was partial disruption of the anterior middle glenohumeral ligament, moderate tendinopathy of the distal supraspinatus tendon with associated partial thickness bursal surface supraspinatus tear in the critical zone, mild subacromial subdeltoid bursitis, borderline narrowing of the subacromial space, and mild acromioclavicular (AC) joint osteoarthritis. The 1/23/15 MRI of the brachial plexus documented symmetric appearance of the scalene musculature with normal appearance anterior and middle scalene muscles. There was normal appearance of the cervical roots and proximal trunks with slight downward deviation of the trunks. There was normal appearance of the brachial plexus nerves. There was moderate narrowing of the right subclavian vein to 6 mm with arms up and mild narrowing of the left subclavian vein to 9 mm (normal 12 mm). The 1/24/15 CT angiogram of the chest was reported normal. There was mild 20% narrowing of the left subclavian artery as it passed behind the anterior scalene which was of doubtful hemodynamic significance. There was no compression on the right subclavian demonstrated. The 2/20/15 neurologic consult cited diffuse pain about the left side of the neck going to the posterior scapula and left shoulder, and extending to the left

side of her face. There were intermittent paresthesias and numbness left arm, mostly in the ulnar digits but at times the whole hand. Left shoulder range of motion was limited. She worked as a lab tech with repetitive use of her hands. Therapy made symptoms worse. There was mild decreased cervical range of motion, negative foraminal compression testing, left trapezius tenderness with trigger points, and mildly reduced left shoulder range of motion. Thoracic outlet maneuvers were equivocal. There was some numbness in the left arm with Adson's, but no obvious drop in radial pulse. Palpation over the scalenes caused pain without paresthesias. Phalen's and Tinel's were mildly positive at the left elbow. Motor testing showed slight give way weakness. Chronic myofascial pain was noted. The differential diagnosis was thoracic outlet syndrome versus ulnar neuritis. Bilateral EMG and MRI arthrogram over the supraclavicular vessels were recommended. The 4/28/15 EMG/NCV study findings were reported as normal. There was no evidence of left arm mononeuropathy, brachial plexopathy, or cervical radiculopathy. The study did not support neurogenic thoracic outlet syndrome. Authorization was requested on 4/29/15 for thoracic outlet syndrome (TOS) decompression for a diagnosis of neurogenic thoracic outlet syndrome. The 5/5/15 utilization review non-certified the request for thoracic outlet syndrome decompression as there was no significant pathology and recent EMG was not consistent with neurogenic thoracic outlet syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

TOS Decompression: Upheld

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

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: Surgery for Thoracic Outlet Syndrome (TOS).

Decision rationale: The California MTUS guidelines indicate the most patients with acute thoracic outlet compression symptoms will respond to a conservative program of global strengthening (with specific exercises) and ergonomic changes. Cases with progress weakness, atrophy, and neurologic dysfunction are sometimes considered for surgical decompression. A confirmatory response to EMG-guided scalene block, confirmatory electrophysiologic testing and/or MR angiography with flow studies are advisable before considering surgery. The Official Disability Guidelines provide specific surgical criteria for neurogenic thoracic outlet syndrome that include physical therapy leading to home exercise for a minimum of 6 months, pain in the affected upper extremity, numbness or paresthesia in the ulnar nerve distribution, and all of the following electrodiagnostic abnormalities must be found: (a) Reduced amplitude median motor response, (b) Reduced amplitude ulnar sensory response, (c) Denervation in muscles innervated by lower trunk of the brachial plexus. Guideline criteria have not been met. This injured worker presents with left upper extremity pain and paresthesias in an ulnar nerve distribution. Records suggested that she had been attending physical therapy since at least February with no improvement. However, the recent EMG does not evidence findings of neurogenic thoracic outlet syndrome to support the medical necessity of surgery. There is no

documentation of an EMG-guided scalene block or positive MR angiography flow studies. Therefore, this request is not medically necessary at this time.