Case Number:	CM15-0163234		
Date Assigned:	08/31/2015	**Date of Injury:**	09/30/2008
Decision Date:	10/09/2015	**UR Denial Date:**	08/12/2015
Priority:	Standard	**Application Received:**	08/19/2015

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, Oregon, Washington
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 46 year old female who sustained an industrial injury on September 30, 2008. The worker was employed as a janitor. Previous treatment modality to include: activity modification, medication, physical therapy, acupuncture therapy and surgical intervention. A primary treating office visit dated February 02, 2015 reported the worker meeting maximal medical improvement with 14 % relating to her depression and anxiety. On March 04, 2015 she underwent internal medicine consultation for stated pre-operative medical management that reported the worker unable to participate with physical therapy due to pain as she did not take pain medication thinking it would trigger nausea if taken on an empty stomach. She is with subjective complaint of nausea contemplating taking an antiemetic medication. Objective assessment found her being status post cervical decompression and fusion; cervical spinal stenosis and radiculopathy; depression, anxiety and nausea. The plan of care noted advancing per surgery. A primary treating office visit note provided for review showed no dated on the document but reported subjective complaint of neck pain radiating down into right arm. She is being referred for orthopedic surgical consultation of the right shoulder under the following diagnoses: fibromyalgia, chronic pain syndrome; status post right lateral epicondyle release January 2012 with residuals; status post two level anterior cervical decompression and fusion in March 2015, and right thoracic outlet syndrome. A neurosurgical re-evaluation dated July 23, 2015 reported subjective complaint of right supraclavicular pain radiating into the right hand associated with weakness and numbness. The impression found the worker with: right posttraumatic thoracic outlet syndrome, and tendinitis of the right supraspinatus tendon.

Objective assessment noted: positive Tinel's of the right brachial plexus. There is recommendation for a surgical decompression of the right brachial plexus. She remains temporarily totally disabled.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgery-Operation to decompress the right brachial plexus: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic).

Decision rationale: Per the ODG, surgery for thoracic outlet syndrome is: "Recommended only as indicated below. Over 85% of patients with acute Thoracic Outlet Compression symptoms will respond to a conservative program, including exercise. While not well supported by quality studies, cases with progressive weakness, atrophy, and neurologic dysfunction are sometimes considered for surgical decompression. A confirmatory response to EMG guided scalene block, and/or confirmatory electrophysiologic testing is advisable before consideration for surgery. Vascular thoracic outlet syndrome (TOS), although much less common than neurologic TOS, requires more urgent care. Thoracic outlet syndrome (TOS) refers to compression of the neurovascular structures at the superior aperture of the thorax. It represents a constellation of symptoms. The cause, diagnosis, and treatment are controversial. The clinical findings in thoracic outlet syndrome (TOS) may be similar to those in carpal tunnel syndrome, ulnar neuropathy, or cervical radiculopathy. A physician should consider these alternative diagnoses before requesting TOS surgery. Most patients with TOS have cervical ribs. Overall, long-term outcomes after TOS surgery are worse than outcomes with medical management of TOS. Surgical intervention (scalenectomy) seems to be the treatment of choice in terms of restoring quality of life and physical activity for professional athletes admitted with thoracic outlet syndrome. Minimally invasive surgery can help selected patients with disabling neurogenic thoracic outlet syndrome (NTOS), and NTOS surgery is especially helpful to adolescents compared with adults. NTOS results from compression of the brachial plexus nerves running either through the neck just above the collarbone or down into the upper chest and just under the collarbone near the shoulder, an area known as the interscalene triangle. In some patients, nerve compression occurs within the subcoracoid space underlying the pectoralis minor muscle tendon near the shoulder, prompting the development of a minimally invasive procedure called pectoralis minor tenotomy (PMT), consisting of detachment of the pectoralis minor tendon. The study compared PMT with traditional open surgery, which combines PMT with supraclavicular decompression (SCD+PMT). After surgery, 82% reported significant and progressive improvement at the 3-month follow-up, including 75% of the patients who underwent isolated PMT and 84% who underwent the combined procedure. See also Electrodiagnostic testing for

TOS (thoracic outlet syndrome). ODG Indications for Surgery; Surgery for Thoracic Outlet Syndrome (TOS): Criteria for Neurogenic TOS: 1. Conservative Care: Physical therapy leading to home exercise for a minimum of 3 months. PLUS 2. Subjective Clinical Findings: In the affected upper extremity, all of the following must be found: (a) Pain, (b) Numbness or paresthesia in the ulnar nerve distribution. PLUS 3. Objective Clinical Findings: In the affected upper extremity, 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. Criteria for Vascular TOS, Arterial: 1. Subjective Clinical Findings: At least three of the following must be present in the affected upper extremity: (a) Pain, (b) Swelling or heaviness, (c) Decreased temperature or change in color, (d) Paresthesias in the ulnar nerve distribution. PLUS 2. Objective Clinical Findings: At least one of the following: (a) Pallor or coolness, (b) Gangrene of the digits in advanced cases. PLUS 3. Imaging Clinical Findings: Abnormal arteriogram Criteria for Vascular TOS, Venous: 1. Subjective Clinical Findings: At least three of the following must be present in the affected upper extremity: (a) Pain, (b) Swelling or heaviness, (c) Decreased temperature or change in color, (d) Paresthesias in the ulnar nerve distribution. PLUS 2. Objective Clinical Findings: At least two of the following: (a) Swelling of the arm, (b) Venous engorgement, (c) Cyanosis. PLUS 3. Imaging Clinical Findings: Abnormal venogram. (Washington, 2002)" In this case there is no evidence of a confirmatory response to EMG guided scalene block, and/or confirmatory electrophysiologic testing. There is also no abnormal arteriogram or venogram. As this patient has not met the ODG criteria for surgery for thoracic outlet syndrome the request is not medically necessary.

Associated surgical services: Consultation-Pre-op consult: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Associated surgical services: EKG 12 leads: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Associated surgical services: X-ray-chest-1 view: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.