

<b>Case Number:</b>	CM15-0185882		
<b>Date Assigned:</b>	09/28/2015	<b>Date of Injury:</b>	05/26/2012
<b>Decision Date:</b>	11/09/2015	<b>UR Denial Date:</b>	08/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/21/2015

### 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

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 26-year-old female, who sustained cumulative industrial trauma injuries from 05-26-2011-05-26-2012. She has reported subsequent neck and bilateral upper extremity pain and was diagnosed with chronic pain syndrome and palmer hyperhidrosis and possible thoracic outlet syndrome. Treatment to date has included pain medication and physical therapy, which were noted to have failed to significantly relieve the pain. In an agreed medical evaluation report dated 07-08-2015, the injured worker reported intermittent slight to moderate neck pain radiating to the arms and into the hands and fingers, intermittent bilateral shoulder pain, occasional elbow pain and bilateral wrist and hand pain with tingling, numbness and weakness. The physician noted that the injured worker had clear findings of thoracic outlet syndrome and that when performing Adson's tests her radial pulse dropped out almost completely on both sides. In a progress note dated 08-14-2015, a 3D MRI-MRA-MRV of the brachial plexus was noted to be positive and consistent with thoracic outlet syndrome with costoclavicular compression of the great vessels and was recommended for therapy and traction. Objective examination findings revealed "bilateral infraclavicular and supraclavicular tenderness with tinel to percussion and positive bilateral Roos test". Work status was documented as temporarily totally disabled. A request for authorization of scalene decompression and cervical traction for thoracic symptoms bilaterally x 12 was submitted. As per the 08-27-2015 utilization review, the request for scalene decompression and cervical traction for thoracic symptoms bilaterally x 12 was non-certified.

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

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

**Scalene decompression and cervical traction for thoracic symptom bilaterally x 12: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care.

**Decision rationale:** Per the MTUS Guidelines, there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, and biofeedback. These palliative tools may be used on a trial basis but should be monitored closely. Emphasis should focus on functional restoration and return of patients to activities of normal daily living. Most patients with acute thoracic outlet compression symptoms will respond to a conservative program of global shoulder strengthening (with specific exercises) and ergonomic changes. While not well supported by high-grade scientific studies, cases with progressive weakness, atrophy, and neurologic dysfunction are sometimes considered for surgical decompression. A confirmatory response to electromyography (EMG) - guided scalene block, confirmatory electrophysiologic testing and/or magnetic resonance angiography with flow studies is advisable before considering surgery. Per the guidelines, there are no high-grade studies to support cervical traction and when used should be done on a trial basis. The request for 12 sessions of cervical traction does not imply a trial. Additionally, there are no high-grade scientific studies to support surgical decompression in thoracic outlet syndrome. The request for scalene decompression and cervical traction for thoracic symptom bilaterally x 12 is determined to not be medically necessary.