

Case Number:	CM14-0014712		
Date Assigned:	02/28/2014	Date of Injury:	01/24/2000
Decision Date:	08/05/2014	UR Denial Date:	01/24/2014
Priority:	Standard	Application Received:	02/05/2014

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 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 35 year old female who was injured on 01/24/2000. The mechanism of injury is unknown. Her diagnoses include cervical muscle spasm, thoracic outlet syndrome, shoulder tendonitis and adhesive capsulitis left, and complex regional pain syndrome. Prior medication history included use of Ultram. The patient underwent cervical medical branch radiofrequency ablation on the left at C5 and C6 on 03/15/2013; and left transaxillary first rib resection, subtotal scalenectomy of the anterior medial and minimus scalene muscles, neurolysis of the brachial plexus, lysis and release of the subclavian artery, lysis and release of subclavian vein on 10/14/2005. On 06/12/2006, she underwent left supraclavicular redo anterior and minimus scalenectomy; redo neurolysis of the brachial plexus, redo lysis and release of the subclavian artery. She has been treated conservatively with bilateral rhomboid trigger point injections and right trapezius trigger point injection on 06/10/2013, 03/29/2013 and intra-muscular medication injection on 10/18/2013. There are no diagnostic studies for review such as previous angiogram dated 12/03/2013, Electromyography (EMG)/Nerve Conduction Velocity (NCV) or arterial studies. On TOS note dated 10/29/2013, the patient presented to the clinic for her thoracic outlet syndrome. She reported her symptoms had returned and she is affected by bilateral pain in her head, neck, shoulders, arms, hands, and fingers. She rates her pain a 7/10. Objective findings on exam revealed AER and EAST are positive bilaterally. Tinel's and Phalen's signs are negative at the carpal and cubital tunnels. Motor and sensory are normal at the ulnar and median nerve distributions. She has no dilated neck veins on exam. There is point tenderness at the left pectoral minor tendon space. Impressions are recurrent thoracic outlet syndrome, possibly neurogenic and rule out pector minor tendon syndrome. She has been recommended for an angiogram and venogram with percutaneous transluminal angioplasty of the head, neck, and arm vessels. Prior utilization review dated 01/22/2014 states the request for repeat angiogram with

percutaneous transluminal angioplasty of brachial cephalic vessels, head, neck and arms is not authorized as there is no supportive documentation to warrant this request.

IMR ISSUES, DECISIONS AND RATIONALES

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

REPEAT ANGIOGRAM WITH PERCUTANEOUS TRANSLUMINAL ANGIOPLASTY OF BRACHIAL CEPHALIC VESSELS, HEAD, NECK AND ARMS: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Boezaart A, et al. Neurogenic Thoracic Outlet Syndrome. International Journal of Shoulder Surgery.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2728415/>.

Decision rationale: Prior trauma-induced neurogenic thoracic outlet syndrome treated after a cervical fusion (2000) by axillary 1st rib resection (2005), repeat supraclavicular anterior scalenectomy with brachial plexus neurolysis (2006), and subsequent thoracoscopic sympathectomy (2009) for clinical symptoms of reflex sympathetic dystrophy. The patient has received multiple evaluations and treatment for left upper extremity pain and disability - representing a complicated clinical condition. The patient has received all of her care at an institution well known for its expertise in TOS management. The patient has developed recurrent left upper extremity symptoms of impressions are recurrent thoracic outlet syndrome (TOS). The recurrent symptoms and signs which upper extremity edema and digit cyanosis, may represent arterial or venous TOS. The clinical diagnosis is possibly neurogenic and rule out pectoralis minor tendon syndrome. The recommendation for an angiogram and venogram with possible percutaneous transluminal angioplasty of the head, neck, and arm vessels is reasonable. The testing would likely include "positional" angiography and venography with arm abduction. In the references cited, upper extremity arterial and venography are the "gold standard" for the valuation of TOS with symptoms and signs of edema and digit ischemia. Imaging provides the exact point(s) of vessel compression. This is particular important in this patient who has sustained trauma and underwent multiple surgical procedures for TOS, including 1st rib resection and subclavian artery mobilization. The use of duplex ultrasound is not diagnostic in the evaluation of recurrent TOS in this patient. Vessel imaging requires positional testing including arm abduction. The rationale for arterial imaging is due to prior 1st rib resection and physical findings suggestive of pectoralis minor tendon syndrome. Use of CT imaging or duplex ultrasound scanning is not accurate for recurrent TOS which may have positional arterial or venous compression. The clinical practice guidelines of the evaluation of recurrent TOS (an uncommon condition) recommends arterial and venous imaging as an appropriate evaluation of a patient with prior trauma and 1st rib resection. The medical records document abnormal signs of edema and digit cyanosis suggestive of arterial and/or venous TOS. The most appropriate and diagnostic testing for this patient is positional arterial and venous imaging. Based on the patient's recurrent TOS symptoms, multiple prior interventions, and physical exam findings, the request is medically necessary and appropriate.