

Case Number:	CM14-0027932		
Date Assigned:	04/23/2014	Date of Injury:	04/12/2011
Decision Date:	05/28/2014	UR Denial Date:	02/25/2014
Priority:	Standard	Application Received:	03/05/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Orthopaedic 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 Physician 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:

This 63-year-old male sustained an industrial injury on 4/21/11 working in a confined curb box, putting in new equipment. He is status post right shoulder subacromial decompression and rotator cuff repair on 9/12/11 and right shoulder revision arthroscopy on 5/24/13. The 3/23/12 cervical MRI showed multilevel moderate to severe foraminal stenosis, left greater than right. The 2/12/14 initial evaluation cited subjective complaints of right-sided neck and arm aching, burning pain. Pain is noted down the right biceps and into the forearm along the C6-7 dermatome. The patient is status post two rotator cuff surgeries with no relief of pain. Pain behaviors were noted. Physical exam noted mild to moderate restriction in neck/shoulder range of motion, moderate right supraclavicular, pectoralis minor, trapezius, and scalene tenderness with muscle twitch response, Tinel's positive at right pectoralis minor, 4/5 right upper extremity strength, and markedly positive Adson's on the right. Ultrasound findings showed right trapezius inflammation/edema, tenting of fascia, and right scalene muscle edema and some fibrotic changes. The diagnosis was cervicgia, brachial plexus Final Determination Letter for IMR Case Number [REDACTED] lesions, neuralgia/neuritis, radiculitis and neurovascular compression. A diagnostic and therapeutic injection was performed under ultrasound guidance but the location and response was not documented. Two trigger point injections were performed to the right pectoralis minor and trapezius. The treatment plan included MRI brachial plexus, right scalene block, referral to physical therapy, and prescriptions for Voltaren XR and Gabapentin. The 2/15/14 utilization review recommended non-certification of the brachial plexus MRI based on an absence of electrodiagnostic testing, focal neurologic deficits, prior focused treatment, and red flags. The scalene block was non-certified based on an absence of documented failure to treatment for thoracic outlet syndrome. The 3/28/14 appeal stated that MRI of the brachial plexus was necessary to provide an adequate study to fully evaluate the structures

potentially contributing to the current symptom complex. Scalene block was recommended as diagnostic and therapeutic. The patient had signs/symptoms consistent with neurovascular compression syndrome arising from the level of the plexus/thoracic outlet with diagnostic testing (MRI plexus) consistent with this process and lack of significant improvement to conservative treatments to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI OF THE RIGHT BRACHIAL PLEXUS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), SHOULDER, THORACIC OUTLET SYNDROME (TOS) DIAGNOSIS; and the non-MTUS Citation: ACR APPROPRIATENESS CRITERIA® PLEXOPATHY. RESTON (VA): AMERICAN COLLEGE OF RADIOLOGY (ACR); 2012. 14p.

Decision rationale: Under consideration is a request for MRI of the right brachial plexus. The California MTUS guidelines do not provide recommendations for brachial plexus MRIs. The American College of Radiology guidelines indicate that MRI of the neck is recommended for evaluation of plexopathy. The Official Disability Guidelines recommend electrodiagnostic testing as reliable for the diagnosis of thoracic outlet syndrome. Guideline criteria have not been met. This employee has a markedly positive cervical MRI for multilevel moderate to severe stenosis and radicular findings in a C6-7 distribution. There is no current electrodiagnostic testing for thoracic outlet syndrome. Guidelines support cervical MRI and electrodiagnostic testing for thoracic outlet syndrome diagnosis. In the absence of inconclusive electrodiagnostic evidence, additional imaging is not warranted at this time. Therefore, this request for MRI of the right brachial plexus is not medically necessary.

RIGHT SCALENE BLOCK: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), SHOULDER, ANTERIOR SCALENE BLOCK.

Decision rationale: Under consideration is a request for a right scalene block. The California MTUS guidelines are silent regarding scalene blocks. The Official Disability Guidelines recommend anterior scalene blocks for relief of acute thoracic outlet syndrome symptoms, and as an adjunct to diagnosis, if the patient fails to respond to exercise. Guidelines criteria have not been met. Physical therapy was prescribed at the time of this request. There is no documentation

that recommended thoracic outlet syndrome exercise has been tried and failed. Therefore, this request for a right scalene block is not medically necessary.

MEDICAL CLEARANCE. H&P, EKG, LABS: 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: Since the primary procedure (right scalene block) is not medically necessary, the associated services are not medically necessary.

RETRO: DIAGNOSTIC/ THERAPEUTIC INJECTION UNDER ULTRASOUND GUIDANCE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), SHOULDER, STERIOD INJECTIONS.

Decision rationale: Under consideration is a retrospective request for diagnostic/therapeutic injection under ultrasound guidance. The California MTUS guidelines do not provide guidance on diagnostic/therapeutic injections for chronic injuries. The Official Disability Guidelines criteria for steroid injections for the treatment of pain not controlled by recommended conservative treatments (physical therapy and exercise, NSAIDs) for at least 3 months. Guidelines indicate that these injections are generally not performed under fluoroscopic or ultrasound guidance. Guideline criteria have not been met. There is no clear documentation in the records as to the location of "the target structure" for the reported local anesthetic/steroid injection. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. Therefore, this retrospective request for diagnostic/therapeutic injection under ultrasound guidance is not medically necessary.

RETRO: TRIGGER POINT INJECTIONS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SECTION TRIGGER POINT INJECTIONS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SECTION TRIGGER POINT INJECTIONS Page(s): 122.

Decision rationale: Under consideration is a retrospective request for trigger point injections. The California MTUS guidelines recommend trigger point injections for the treatment of

myofascial pain syndrome when symptoms have persisted for longer than 3 months and medical management therapies, such as stretching exercises, physical therapy, NSAIDs and muscle relaxants, have failed to control pain. Additionally, radiculopathy should not be present by exam, imaging or neurologic testing. Guideline criteria have not been met. There is no detailed documentation that recent recommended comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. The treating physician documented a radicular pain distribution along the right C6-7 dermatome. Therefore, this retrospective request for trigger point injections is not medically necessary.