MAXIMUS Federal Services

Case Number:	CM15-0015482		
Date Assigned:	02/04/2015	Date of Injury:	05/13/2010
Decision Date:	03/26/2015	UR Denial Date:	01/06/2015
Priority:	Standard	Application Received:	01/27/2015

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: Minnesota, Florida
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 was a 39 year old female, who sustained an industrial injury, May 15, 2008. According to progress note of December 19, 2014, the injured workers chief complaint was sharp pain in the neck that radiates into the shoulders and arms and into the fingers of the right hand. The injured worker complains of numbness in the right small and ring finger. The injured worker was also experiencing migraine headaches associated nausea and vomiting. The pain was aggravated by any activity. The pain was scaled 7 out of 10; 0 being no pain and 10 being the worse pain. The injured worker also complains of low back pain that radiates into both hips and legs, left greater than the right with spasms and numbness in the left toes. The injured worker was diagnosed with chronic neck pain, cervical radiculopathy, anxiety, depression, joint pain, migraine headache, C7-T1 laminectomy in 2009, C7-T1 disc replacement and then subsequently a C6-T1 posterior fusion. The injured worker previously received the following treatments pain medications, TENS (transcutaneous electrical nerve stimulator) unit, laboratory studies, MRI of the cervical spine August 10, 2012, CT scan of the cervical spine April 28, 2010, heat and ice. On December 19, 2014, the primary treating physician requested authorization for surgical decompression by scalenectomy on the right. On January 6, 2015, the UR denied authorization for scalenectomy. The denial was based on the MTUS/ACOEM and ODG guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Scalenectomy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, 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, Section: Shoulder, Topic: Surgery for Thoracic Outlet Syndrome

Decision rationale: The diagnosis of Thoracic outlet syndrome has not been confirmed, The MRI scan was limited by motion and metal artifacts and furthermore it is not a reliable diagnostic test. There were no cervical ribs present. ODG guidelines indicate for neurologic thoracic outlet syndrome electrodiagnostic testing is reliable. The diagnostic criteria include the presence of all 3 of the following: 1. Amplitude of median motor response is reduced and 2. Amplitude of ulnar sensory response is reduced and 3. Needle exam shows denervation in muscles innervated by the lower trunk of the brachial plexus. The electromyographer should also rule out neuropathic conditions that might mimic thoracic outlet syndrome, specifically cervical radiculopathy, carpal tunnel syndrome, ulnar neuropathy, and polyneuropathy. The documentation does not include evidence of these findings to establish a diagnosis. There is also no documentation of a specific 3 months conservative treatment program including exercise that is recommended. 85% of patients will respond to such a program. With regard to the arterial thoracic outlet syndrome the criteria include subjective clinical findings of pain, swelling, and decreased temperature or change in color, paresthesias in the ulnar distribution, plus objective findings of pallor or coldness plus imaging clinical findings of abnormal arteriogram. For venous thoracic outlet syndrome swelling of the arm, venous engorgement or cyanosis plus imaging clinical findings of abnormal venogram are necessary to make a diagnosis. The documentation does not indicate specific diagnostic testing other than the non-diagnostic MRI scan. A confirmatory response to EMG guided scalene block and/or confirmatory electrophysiologic testing is advisable before consideration for surgery. Overall the long-term outcomes after thoracic outlet syndrome surgery are worse than outcomes with medical management of thoracic outlet syndrome. Therefore surgery is not a good option. Electrodiagnostic abnormalities of reduced amplitude median motor response, reduced amplitude ulnar sensory response, and denervation in muscles innervated by lower trunk of the brachial plexus need to be present for surgical consideration. The documentation provided does not meet the diagnostic and surgical criteria for neurologic, arterial, or venous thoracic outlet syndrome and the guideline criteria for surgery are not present. As such, the request for Scalenectomy is not supported and the medical necessity of the request is not established.