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| Case Number: | CM15-0173673 | | |
| Date Assigned: | 09/24/2015 | Date of Injury: | 10/31/2012 |
| Decision Date: | 10/28/2015 | UR Denial Date: | 08/03/2015 |
| Priority: | Standard | Application Received: | 09/03/2015 |

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 27 year old female, who sustained an industrial injury on 10-31-2012. The injured worker was being treated for cervical spine strain, right elbow strain and lateral epicondylitis, right wrist and hand sprain and strain, carpal tunnel syndrome, left elbow medial epicondylitis-compensatory consequence due to favoring, left wrist strain-compensatory consequence due to favoring, thumb pain-compensatory consequence due to favoring, and neurovascular compression, TOS right upper extremity status post decompression on 5-21-2015. On 7-20-2015, the injured worker reported continued right hand pain, rated 5 out of 10. She reported improved range of motion by physical therapy, but soreness and burning persisted. She reported continued cervical spine pain. The treating physician noted surgery helped the pressure feeling and right hand and elbow symptoms persisted. There was no documented physical exam on 7-20-2015, as the treating physician noted the exam was unchanged since the last visit. On 8-2-2013, an MRI of the cervical spine was unremarkable. On 11-15-2013, electromyography and nerve conduction studies of the bilateral upper extremities revealed borderline carpal tunnel syndrome. On 5-21-2015, the injured worker underwent a right first rib resection, subtotal resection of the subclavius muscle, anterior scalene muscle and middle scalene muscle, resection of scalene minimus muscles, neurolysis of brachial plexus, and lysis of subclavian artery. On March 24, 2015, the injured worker underwent a right scalene muscle block injection and right trapezius muscle trigger point injections. Treatment has included physical therapy, chiropractic therapy, acupuncture, a home exercise program, off work, work modifications, a wrist splint, and medications including pain (Norco) and non-steroidal anti-inflammatory (Motrin). Per the

treating physician (7-20-2015 report), the injured worker is temporarily totally disabled. On 7-21-2015, the requested treatments included a right total scalene muscle resection and inpatient stay for 2 days. On 8-3-2015, the original utilization review non-certified a request for a right total scalene muscle resection and inpatient stay for 2 days.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right total scalene muscle resection: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, surgery for thoracic outlet syndrome.

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. (Washington, 2002) (Wickizer, 2004) 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. (Baltopoulos, 2008) 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. (Vemuri, 2013) 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 the patient does not meet ODG criteria for thoracic outlet syndrome surgery. Additionally the EMG from 11/15/13 only showed mild carpal tunnel syndrome. Therefore is not medically necessary.

Inpatient stay for 2 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Hospital Length of Stay.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, surgery for thoracic outlet syndrome.

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.