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**Notice of Independent Review Decision**

DATE OF REVIEW: 11/25/14

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

RT- First Rib Resection, CPT: 21615; RT- Brachial Plexus Neurolysis, CPT: 64713

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Physician Board Certified in Neurosurgery.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

<b>Upheld</b>	<b>(Agree) <u>X</u></b>
Overtured	(Disagree)
Partially Overtured	(Agree in part/Disagree in part)

ODG (Official Disability Guidelines)

PATIENT CLINICAL HISTORY SUMMARY

was working in xx/xxxx. her right shoulder hyper-extended. She was initially treated conservatively. In October of 2009, she underwent an MRI scan of the right shoulder which showed tendonosis of the supraspinatus tendon as well as fluid in the subacromial and sub deltoid space as well as acromial clavicular joint arthropathy with a small ganglion without medial or lateral outlet impingement. She then underwent physical therapy and other conservative therapy without improvement until March of 2010 at which point she underwent a right shoulder arthroscopy. Post-operatively, she had more physical therapy. In 2011 she had an EMG which did not show any evidence of significant nerve root, brachial plexus, or peripheral nerve disfunction. She also underwent continued evaluation of her right shoulder and was ultimately diagnosed with multidirectional instability of the right shoulder.

She then moved and was again evaluated for persistent right shoulder pain. She was evaluated who felt that she continued to have symptoms from multidirectional instability of the shoulder and he referred her for his opinion on whether or not she also had a thoracic outlet syndrome.

She underwent a clinical evaluation followed by non-invasive duplex studies which showed no evidence of venous thrombosis, a less than 50% stenosis of the subclavian artery on the right, a greater than 50% stenosis of the subclavian artery on the left and also had a photo plethysmograph which showed some abnormalities, bilaterally, greater on the right. She had an MRI scan of the cervical spine which showed degenerative changes at C4-5, C6-7, and C7, T1 without significant central or nerve foraminal stenosis. She also had an EMG of the upper extremities which again did not show any significant disfunction of a nerve root, brachial plexus, or peripheral nerve.

PATIENT CLINICAL HISTORY SUMMARY (continuation)

She had a right scalene block performed which clinically resulted in relief of her symptoms for a short period of time. She also went back to physical therapy. Ultimately, she went back. considered surgery for her multidirectional instability, but felt that she should have all sources of non shoulder pain resolved prior to surgery. felt that her symptoms were consistent with thoracic outlet syndrome and ultimately recommended a right first rib resection and right brachial plexus neurolysis.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION

**Opinion: I agree with the benefit company's decision to deny the requested service of a Right First Rib Resection, CPT: 21615. I agree with the benefit company's decision to deny the requested service of a Right Brachial Plaxus Neurolysis, CPT: 64713**

**Rationale:** There are two types of neurogenic claudication, neurogenic and vascular. First, it is not clear or documented whether or not feels that thoracic outlet syndrome is neurogenic or vascular. Second, has had two separate EMG's which show no evidence of significant nerve root, brachial plexus, or peripheral nerve injury. There are also no imaging studies documenting potential compression of the brachial plexus by a cervical rib or other musculoskeletal structures. In the absence of any EMG evidence of brachial plexus dysfunction, the brachial plexus neurolysis would be unlikely to be of any clinical benefit.

If it is felt that thoracic outlet syndrome is vascular, it would still be unlikely for a brachial plexus neurolysis to result in any benefit. Furthermore, non-invasive studies are not predictive of success with surgery. Furthermore, Ms has vascular abnormalities which, if anything, are greater on the opposite side of her symptoms, and a more definitive diagnostic test for dynamic arterial occlusion has not been performed.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL  
MEDICINE UM KNOWLEDGE BASE  
AHCPR-AGENCY FOR HEALTH CARE RESEARCH & QUALITY GUIDELINES  
DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE & EXPERTISE IN ACCORDANCE WITH  
ACCEPTED MEDICAL STANDARDS**

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

**ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE  
(PROVIDE DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES  
(PROVIDE DESCRIPTION)