

<b>Case Number:</b>	CM14-0199448		
<b>Date Assigned:</b>	12/10/2014	<b>Date of Injury:</b>	01/01/2011
<b>Decision Date:</b>	01/26/2015	<b>UR Denial Date:</b>	11/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/28/2014

### 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 Orthopedic Surgery, and is licensed to practice in New York. 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:

Patient is a 40 year old female with date of injury of January 11, 2011. The patient got injured from chronic work in front of a computer. The patient has had injections in the right shoulder with no improvement. Physical examination shows decreased sensation in the right hand. There is no muscle atrophy. Grip strength was reduced to 4/5. There is significant pain over the brachial plexus on the right side with positive Tinel's over the brachial plexus. Sensation of the torso was normal. Diagnoses include cervicalgia and brachial neuritis. The patient has been treated with conservative measures with no improvement. MRI the cervical spine shows right disc extrusion at C3-4. There is also a disparaging at C6-7 causing foraminal narrowing. There is neuroforamen also at C5-6. At issue is whether Brachial Plexus Neurolysis is medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Brachial Plexus Neurolysis: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines Post Surgical Rehabilitation Page(s): 22.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder chapter, MTUS shoulder chapter

**Decision rationale:** This patient does not meet establish criteria for Brachial Plexus Dura Lysis. Specifically the diagnosis of Brachial Plexus Neuropathy has not been clearly established. The patient has MRI evidence of multiple nerve root compression the cervical spine. Physical examination does not clearly document brachial plexus pathology. Also, results of Brachial Plexus Neuralysis remain unclear in the long-term. Criteria for Brachial Plexus Neuralysis are not met. There is no clear-cut Brachial Plexus Neuropathy documented medical records. The request for Right Brachial Plexus Neurolysis is not medically necessary.

**Pre-Operative Clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Wheelless Textbook of Orthopedics Online, ODG

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Inpatient Stay x 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 (ODG), Hospital Length of Stay

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Post-Operative Aquatic Therapy 3 x 6 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22, Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.