

Case Number:	CM13-0058709		
Date Assigned:	12/30/2013	Date of Injury:	11/10/1995
Decision Date:	05/07/2014	UR Denial Date:	10/23/2013
Priority:	Standard	Application Received:	11/27/2013

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 Family Practice and is licensed to practice in Texas. 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:

The injured worker is a 59-year-old male who reported an injury on 11/10/1995 after he witnessed a motor vehicle accident. The injured worker's treatment history included multiple medications, psychiatric support, physical therapy, aquatic therapy, and trigger point injections. The injured worker was evaluated on 09/24/2013. It was documented that the injured worker had increased right knee pain rated at a 6/10. It was documented that medication usage assisted with pain control for the injured worker. The injured worker's medications included Anaprox, Oxycodone, and Pennsaid 1.5% solution. It was noted that there was no evidence of withdrawal or overdose. Physical findings included limited right knee range of motion and limited left knee range of motion secondary to pain. The injured worker's diagnoses included musculoligamentous injury to the shoulder, impingement syndrome, rotator cuff tendinitis, acromioclavicular sprains and strains, depression, internal derangement of the knees bilaterally, wrist derangement, shoulder scapulothoracic musculotendinous injury, patellofemoral syndrome in the bilateral knees, difficulty walking, disc bulging of the lumbosacral spine, lumbar facet arthropathy, radiculopathy of the lumbosacral spine, bicipital tenosynovitis of the bilateral shoulders, medial and lateral epicondylitis of the left elbow, trochanter bursitis of the left elbow, sacroiliac dysfunction, insomnia, shoulder arthroscopy, elbow arthroscopy, knee arthroscopy bilaterally, bilateral medial meniscus tears, and "musculotendiniligamentous" sprain/strain. The injured worker's treatment plan included genetic testing and continuation of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

GENETIC TESTING: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG PAIN CHAPTER

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN CHAPTER, GENETIC TESTING FOR POTENTIAL OPIOID ABUSE

Decision rationale: The requested Genetic Testing is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address genetic testing. Official Disability Guidelines do not recommend genetic testing for the purpose of determining appropriate medications for specific injured workers. The Official Disability Guidelines state that this type of testing is still considered highly investigational and does not consistently provide medically appropriate results. The clinical documentation submitted for review does not provide any evidence to support extending treatment beyond guideline recommendations. As such, the requested Genetic Testing is not medically necessary or appropriate.

PENNSAID 1.5%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The requested Pennsaid 1.5% is not medically necessary or appropriate. Chronic Pain Medical Treatment Medical Treatment Guidelines does not recommend the long term use of topical anti-inflammatory drugs. The clinical documentation submitted for review does indicate that the injured worker has been on this medication for an extended period of time. Additionally, there is no documentation that the injured worker has failed to respond to oral formulations of nonsteroidal anti-inflammatory drugs. There is no documentation that oral formulations of nonsteroidal anti-inflammatory drugs are contraindicated for the injured worker. Therefore, the need for this medication is not clearly established within the documentation. Additionally, the request as it is submitted does not provide an appropriate body part, dosage, or frequency or duration of treatment. Therefore the appropriateness of the request itself cannot be determined. As such, the requested Pennsaid 1.5% is not medically necessary or appropriate.