

Case Number:	CM15-0204891		
Date Assigned:	10/21/2015	Date of Injury:	07/31/2012
Decision Date:	12/08/2015	UR Denial Date:	10/12/2015
Priority:	Standard	Application Received:	10/19/2015

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: New York, Tennessee

Certification(s)/Specialty: Emergency Medicine

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 61 year old male, who sustained an industrial injury on 07-31-2015. A review of the medical records indicates that the injured worker (IW) is undergoing treatment for left lumbar radiculopathy and right shoulder pain. Medical records (03-02-2015 to 09-21-2015) indicate ongoing right shoulder, radiating low back and right knee pain. Pain levels were rated 3-6 out of 10 in severity on a visual analog scale (VAS) for the right shoulder, 5-7 out of 10 for the low back, and 3 out of 10 for the right knee. Records also indicate no changes in activity level or level of functioning. Per the treating physician's progress report (PR), the IW was permanent and stationary. The physical exam, dated 09-21-2015, revealed tenderness over the anterior aspect and the acromioclavicular (AC) joint of the right shoulder, swelling in the right shoulder, atrophy of the deltoid muscle, restricted range of motion (ROM) in the right shoulder, tenderness over the lumbar spine with restricted ROM, minute sensation in the L5-S1 dermatomal distributions, and mild tenderness over the medial aspect of the left knee with mildly restricted ROM. Relevant treatments have included: 2 right shoulder surgeries, physical therapy (PT), shockwave therapy, work restrictions, and pain medications (hydrocodone since at least 03-2015). The treatment plan was to include DNA testing to rule out metabolic pathway deficiency for proper medication selection and management. The PR and request for authorization (09-21-2015) shows that the following medication and diagnostic test were requested: 1 DNA genetic test, and hydrocodone 10mg. The original utilization review (10-12-2015) non-certified the request for 1 DNA genetic test and hydrocodone 10mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 DNA/genetic testing: 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), Pain (Chronic), Genetic testing for potential opioid abuse, Pharmacogenetic testing/pharmacogenomics.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation UpToDate: Overview of pharmacogenomics.

Decision rationale: Pharmacogenomics is the study of the role of inherited and acquired genetic variation on drug response. In theory, the identification of genetic factors that influence drug absorption, metabolism, and action at the receptor level should allow for individualized therapy. Several problems in study design have limited the translation of pharmacogenetics into the clinical sphere and studies have not been reproducible. Medical evidence to support the validity genetic testing for drug response is not consistent. The request should not be authorized. Therefore, the requested treatment is not medically necessary.

Hydrocodone 10mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: Hydrocodone is an opioid medication. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain or function. It is recommended for short-term use if first-line options, such as acetaminophen or NSAIDs have failed. In this case the patient has been receiving hydrocodone since at least June 2013 and has not obtained analgesia. In addition there is no documentation that the patient has signed an opioid contract. Criteria for long-term opioid use have not been met. The request should not be authorized. Therefore, the requested treatment is not medically necessary.