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| Case Number: | CM15-0021580 | | |
| Date Assigned: | 02/11/2015 | Date of Injury: | 09/08/1998 |
| Decision Date: | 04/06/2015 | UR Denial Date: | 01/14/2015 |
| Priority: | Standard | Application Received: | 02/04/2015 |

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: Arizona, California, Florida
 Certification(s)/Specialty: Family Practice

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 60-year-old female who reported an injury on 09/08/1998. The mechanism of injury was not provided. The documentation of 12/16/2014 revealed the injured worker had no new complaints. The injured worker had pain in the right shoulder and lumbar spine with radiation into the left leg. Range of motion was decreased and there was tenderness. The diagnoses included left shoulder pain, myoligamentous strain of the lumbar spine with disc protrusion, stenosis and grade 1 anterolisthesis, and exacerbation of the right shoulder pain with rotator cuff and SLAP lesion tear per MRI. The treatment plan included genetic testing for prescription drug metabolism to aid in proper dosing and assessment of dependency, tolerance, and effectiveness or misuse. The medications were not provided. There was Request for Authorization submitted for review dated 12/16/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Advanced DNA test 12-16-14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cytokine DNA.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cytokine DNA Testing for Pain Page(s): 42.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines do not recommend DNA testing. The documentation indicated that the request was made to aid in proper dosing and assessment of dependency, effectiveness or misuse. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. Given the above, the request for retro advanced DNA test 12-16-14 is not medically necessary.