

Case Number:	CM15-0023466		
Date Assigned:	02/13/2015	Date of Injury:	03/28/2008
Decision Date:	04/07/2015	UR Denial Date:	01/28/2015
Priority:	Standard	Application Received:	02/09/2015

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: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 54-year-old female who reported injury on 03/28/2008. The mechanism of injury was repetitive packing and moving papers. The injured worker was noted to have an MRI of the cervical spine and an EMG. Prior therapies included a left wrist carpal tunnel release, injections, physical therapy, splints, bracing, medications, and other modalities. The documentation indicated the injured worker had been maintained on tramadol/APAP, Prilosec, and LidoPro topical analgesic for pain. The documentation of 12/08/2014 revealed the medications and transdermal creams were helping with pain. The injured worker was taking cyclobenzaprine. The injured worker had decreased range of motion of the right wrist, right shoulder, and lumbar spine. The diagnoses include cervical C5 radiculopathy per electrodiagnostic studies, full thickness tear of the supraspinatus tendon, and partial thickness tear of the distal infraspinatus tendon in the right shoulder per MRI. The treatment included genetic testing for prescription drug metabolism in order to aid in proper dosing and assessment of dependency, tolerance, and evidence of misuse. There was a Request for Authorization submitted to support the request dated 12/23/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro DNA Kit: Upheld

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

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 clinical documentation indicated the request was made for genetic testing for prescription drug metabolism to aid in proper dosing and assessment of dependency, tolerance, effectiveness, and misuse. However, as it is not recommended by the guidelines, this request would not be supported. As such, the request for retro DNA kit is not medically necessary. Additionally, the request as submitted failed to indicate the date of service being requested.