MAXIMUS Federal Services

Case Number:	CM14-0113586		
Date Assigned:	08/01/2014	Date of Injury:	06/18/2013
Decision Date:	09/17/2014	UR Denial Date:	06/20/2014
Priority:	Standard	Application Received:	07/21/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 62-year-old male who reported an injury on 06/18/2013. The mechanism of injury was not provided within the documentation submitted for review. His diagnosis was noted to be glenoid labrum lesion. Prior treatments were noted to be chiropractic care, physical therapy, and home exercise. He was noted to have surgery on 05/17/2014. The injured worker was status post left rotator cuff full-thickness repair. Diagnostic testing includes x-rays and an MRI. An operative note on 05/17/2014 noted the injured worker with ongoing pain in the left shoulder, difficulty with activities. The MRI showed a full-thickness tear of the supraspinatus tendon. The injured worker then received left shoulder arthroscopic synovectomy, and subacromial decompression with debridement to the labrum. The postoperative instructions state elevation, cold therapy, sling, antibiotics, and instructions to be protective for a total period of 6 weeks postoperatively to allow healing to take place. The provider's rationale for the request was not noted within the retrospective examination date. A Request for Authorization form was not provided within the review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Sprix 15.75mg Nasal Spray #1 (Date of Service: 05/17/14): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Sprix (ketorolac tromethamine nasal Spray.

Decision rationale: The request for retrospective Sprix 15.75 mg nasal spray #1, date of service 05/17/2014, is not medically necessary. The operative report includes postoperative instructions. It is not noted that there was an order or instructions to use the medication in the request. In addition, the guidelines do not recommend Sprix. This medication is used for short-term management of moderate to moderately severe pain, requiring analgesia at the opioid level. A total duration of use of this intranasal formulation, as with other ketorolac formulations, should be for the shortest duration possible and not exceed 5 days. The provider's request fails to indicate a usage frequency and duration of treatment. As such, the request for retrospective Sprix 15.75 mg nasal spray #1, date of service 05/17/2014, is not medically necessary.