

<b>Case Number:</b>	CM14-0029572		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	10/17/2012
<b>Decision Date:</b>	07/17/2014	<b>UR Denial Date:</b>	03/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/07/2014

### 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 and Rehabilitation and is licensed to practice in Illinois. 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 38-year-old male who reported an injury on 10/17/2012. The mechanism of injury was noted to be a physical altercation. Prior treatment was noted to be physical therapy and non-steroidal anti-inflammatory drug (NSAIDs). The injured worker's diagnoses included a rotator cuff sprain/strain. It is noted in a clinical note on 06/02/2014 that the injured worker has left shoulder pain and discomfort occasionally. On 01/07/2014, he underwent arthroscopy, bursoscopy, and correction surgery to the left shoulder. Postoperatively, the injured worker was given range of motion exercises and scheduled for formal physical therapy to begin on 01/08/2014. The request is for a retrospective pharmacy purchase with a date of service of 01/07/2014. The Request for Authorization form was not provided within the documentation. The provider's rationale for the requested Sprix cap was not provided within the documentation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective pharmacy purchase of Sprix cap 15.75mg #40 for DOS 1/07/14: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation The Official Disability Duration Guidelines, Treatment in Workers Compensation, 2014 web-based edition.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list and adverse effects Page(s): 70-73.

**Decision rationale:** The request for the retrospective pharmacy purchase of Sprix cap 15.75 mg (Quantity: 40.00) for the date of service of 01/07/2014 is non-certified. The California Medical Treatment Utilization Schedule (MTUS) Guidelines state ketorolac is not indicated for minor or chronic painful conditions. The documentation provided does not indicate a rationale for why the injured worker was placed on ketorolac. There is a lack of objective findings to indicate the need for a prescription NSAID. In addition, the provider failed to indicate a frequency of the medication requested. Therefore, the request for the retrospective pharmacy purchase of Sprix cap 15.75 mg (Quantity: 40.00) for the date of service of 01/07/2014 is not medically necessary and appropriate.