

<b>Case Number:</b>	CM15-0006493		
<b>Date Assigned:</b>	01/26/2015	<b>Date of Injury:</b>	08/12/2011
<b>Decision Date:</b>	03/23/2015	<b>UR Denial Date:</b>	01/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/12/2015

### 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 50-year-old female who reported an injury on 08/12/2011. The mechanism of injury was not specifically stated. The current diagnoses include cervical disc bulge, lumbar pain, status post right subacromial decompression on 06/23/2014, right carpal tunnel syndrome, and right shoulder adhesive capsulitis. The injured worker presented on 11/26/2014 with complaints of mid and low back pain, right shoulder pain, right arm pain, and bilateral lower extremity pain. The injured worker was utilizing Ambien, Naproxen, hydrocodone, and tizanidine. Upon examination, there was tenderness at the anterior and lateral deltoid, tenderness at the biceps tendon, acromioclavicular joint pain, 90 degree abduction, 60 degree internal rotation, 60 degree external rotation, 10 degree adduction, 3+/5 motor weakness on abduction, and intact sensation. Recommendations at that time included a right shoulder closed manipulation. Postoperative durable medical equipment, as well as a prescription for Sprix nasal spray 15.75 mg was requested. There was no Request for Authorization form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Sprix Nasal Spray (5 bottles): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Sprix (ketorolac tromethamine nasal Spray).

**Decision rationale:** California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second line option after acetaminophen. The Official Disability Guidelines state Sprix nasal spray is recommended for the short term management of moderate to moderately severe pain requiring analgesia at the opioid level. In this case, there was no indication of moderate to moderately severe pain. The injured worker was noted to be utilizing opioid medication, as well as an NSAID. The medical necessity for Sprix nasal spray has not been established. There is also no frequency listed in the request. As such, the request is not medically appropriate.