

Case Number:	CM13-0049760		
Date Assigned:	12/27/2013	Date of Injury:	09/29/2003
Decision Date:	04/16/2014	UR Denial Date:	10/17/2013
Priority:	Standard	Application Received:	10/23/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine, and is licensed to practice in Hawaii. 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 physician 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:

This patient is a 30 year old female with a date of injury of 9/29/2003. Medical documentation indicates the patient is undergoing treatment for chronic low back pain, chronic pain syndrome, chronic pain related insomnia, myofascial syndrome, and neuropathic pain. Subjective complaints include 6/10 pain with medications and 7-8/10 pain without medication, left leg pain, low back pain with radiation to the groin and tailbone. Objective findings (8/29/2013) include point tenderness over the L5 spinous process, decreased flexion, extension, and lateral bending of lumbar spine. Medications have included percocet 5/325mg twice daily, medrox patch nightly, lyrica 75mg twice daily, and centraline PM two pills at bedtime. A utilization review dated 10/11/2013 non-certified a request for percocet 5/325mg #60 and centraline (sintralyn) PM #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

PERCOCET 5/325MG #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Opioids.

Decision rationale: Percocet (oxycodone with acetaminophen) is a short-acting opioid. Chronic Pain Guidelines and ODG do not recommend opioid therapy "except for short term use for severe cases, not to exceed 2 weeks" and "routine long-term opioid therapy is not recommended, and ODG recommends consideration of a one-month limit on opioids for new chronic non-malignant pain patients, as there is little research to support use. The research available does not support overall general effectiveness and indicates numerous adverse effects with long-term use. The latter includes the risk of ongoing psychological dependence with difficulty weaning." Medical documents indicate that the patient has been on Percocet for several months, in excess of the recommended 2-week limit. Additionally, indications for when opioids should be discontinued include "If there is no overall improvement in function, unless there are extenuating circumstances". The treating physician does document some pain level improvement, however, does not document overall improvement in function, which is required for continued use of this medication. As such, the request for Percocet 5/325mg #60 is not medically necessary.

CENTRALINE PM #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) CHRONIC PAIN, INSOMNIA TREATMENT, MELATONIN, MEDICAL FOOD

Decision rationale: Centraline (sintralyne) is a melatonin/gamma-aminobutyric acid/herbal complex no.183 supplement with is reported to be used as a sleep aid. ACOEM, MTUS and ODG are silent regarding sintralyne. Regarding melatonin monotherapy, ODG states "Recommended. See Insomnia treatment. There are also experimental and clinical data supporting an analgesic role of melatonin. In published studies melatonin shows potent analgesic effects in a dose-dependent manner, and melatonin has been shown to have analgesic benefits in patients with chronic pain. Also, the repeated administration of melatonin improves sleep and thereby may reduce anxiety, which leads to lower levels of pain." Gamma-aminobutyric acid (GABA) is further specified by ODG, "This supplement is indicated for epilepsy, spasticity and tardive dyskinesia." The medical documentation does not indicate treatment for epilepsy, spasticity, and tardive dyskinesia. Additionally, ODG states "There is no high quality peer-reviewed literature that suggests that GABA is indicated for treatment of insomnia. Adverse reactions associated with treatment include hypertension, increased heart rate and anxiety." Literature search failed to reveal the contents of "herbal complex no.183". Other than the request for sintralyne, the treating physician does not document what other insomnia treatment has been tried (and the results of the treatment), such as stimulus control, progressive muscle relaxation, paradoxical intention, and establishing sleep hygiene. As such, the request for Centraline (sintralyne) is not medically necessary