

<b>Case Number:</b>	CM14-0194781		
<b>Date Assigned:</b>	12/02/2014	<b>Date of Injury:</b>	07/29/1998
<b>Decision Date:</b>	01/28/2015	<b>UR Denial Date:</b>	10/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/20/2014

### 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 Anesthesiology, has a subspecialty in Pain medicine and acupuncture and is licensed to practice in California. 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:

This 71 year old female sustained a work related injury on 07/29/1998. The mechanism of injury was not made known. According to an office visit dated 07/30/2014, the injured worker used Ambien for insomnia due to pain and Aciphex to offset dyspepsia from her medication regimen. According to an office visit dated 10/14/2014, the injured worker complained of worsening back pain that radiated to her right leg with a burning sensation. She rated her pain 9 on a scale of 1-10. With medications pain was rated 4 and without medication a 10. She reported 50 percent reduction in pain, 50 percent functional improvement with activities of daily living and work duties with medications. Abdomen was soft, non-tender with positive bowel sounds heard throughout. Lower back exam revealed limited range. She could forward flex 30 degrees, extend 10 degrees. Right and left straight leg raise were both 80 degrees, causing right-sided back pain that radiated to the right buttock and posterior thigh. She reported altered sensory loss to light touch and pinprick at the right lateral calf and bottom of her foot. She ambulated with a limp with the right lower extremity. Deep tendon reflexes were +1 at the knees and ankles. Toes were down going to plantar reflex bilaterally. There was good 5/5 strength in the lower extremity muscle groups tested. Impression included history of lumbar laminectomy at L5-L6 level with chronic back pain and right radicular symptoms, neurogenic claudication leg cramps right leg, dyspepsia of medication course, insomnia due to pain, history of neck pain and history of ACDF neck fusion nonindustrial stable and neuropathic burning pain in the right lower extremity stable with Neurontin. According to the provider, the injured worker was under a narcotic contract and urine drug screens had been appropriate. On 10/21/2014 Utilization Review modified Zolpidem Tartrate 10mg #30 (2) refills and non-certified Rabeprazole 20mg #30 (5) refills that was requested on 10/13/2014. According to the Utilization Review Physician in regards to Zolpidem Tartrate, there was no clear documentation of sleep history including hours of sleep, sleep

hygiene, nocturnal awakenings and daytime sleepiness as well as evidence of objective functional benefit with prior use of medication. It was noted that the injured worker was prescribed this medication on 09/26/2013. This medication is approved for short-term (usually two to six weeks) treatment of insomnia. In regards to Rabeprazole, the Utilization Review physician noted that this medication is an "N" drug on the Official Disability Guidelines formulary and that there was no documentation of trialed and failed "Y" drugs or documentation that this medication is superior to a "Y" drug. This decision was appealed for an Independent Medical Review.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Zolpidem Tartrate 10mg at bedtime for insomnia due to pain, #30 with 2 refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC Pain Procedure Summary (updated 10/2/14)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Zolpidem (Ambien).

**Decision rationale:** The MTUS is silent on the treatment of insomnia. With regard to Ambien, the ODG guidelines state "Zolpidem is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term." The documentation submitted for review do not contain information regarding sleep onset, sleep maintenance, and sleep quality and next-day functioning. It was not noted whether simple sleep hygiene methods were tried and failed. The request is not medically necessary.

**Rabeprazole 20mg daily for dyspepsia, #30 with 5 refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC Pain Procedure Summary (updated 10/2/14)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68.

**Decision rationale:** In the treatment of dyspepsia secondary to NSAID therapy, the MTUS recommends stopping the NSAID, switching to a different NSAID, or considering the use of an

H2-receptor antagonist or a PPI. The MTUS Chronic Pain Medical Treatment Guidelines recommend the use of proton pump inhibitors in conjunction with NSAIDs in situations in which the patient is at risk for gastrointestinal events including: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). CPMTG guidelines further specify: "Recommendations: Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g., Ibuprofen, Naproxen, etc.). Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is Naproxyn plus low-dose aspirin plus a PPI. Per ODG TWC, "many prescribers believe that this class of drugs is innocuous, but much information is available to demonstrate otherwise. A trial of omeprazole or Lansoprazole is recommended before Nexium therapy. The other PPIs, Protonix, Dexilant, and Aciphex, should also be second-line. "As there is no documentation of peptic ulcer, GI bleeding or perforation, or cardiovascular disease in the records available for my review, the injured worker's risk for gastrointestinal events is low, as such, medical necessity cannot be affirmed. Furthermore, as noted per the guidelines, Aciphex is a second-line medication. The medical records do not establish whether the patient has failed attempts at first line PPIs, such as omeprazole or Lansoprazole, which should be considered prior to prescribing a second line PPI such as Protonix. The request is not medically necessary.