

<b>Case Number:</b>	CM15-0105155		
<b>Date Assigned:</b>	06/09/2015	<b>Date of Injury:</b>	09/15/2008
<b>Decision Date:</b>	08/12/2015	<b>UR Denial Date:</b>	05/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/01/2015

### 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: New Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 is a 29 year old male with a September 15, 2008 date of injury. A progress note dated January 14, 2014 documents subjective complaints (lower back pain that radiates bilaterally to the lower extremities; lower extremity pain bilaterally in the knees; difficulty sleeping; pain rated at a level of 3/10 with medications, and 8/10 without medications), objective findings (spinal vertebral tenderness noted in the cervical spine; moderately limited range of motion of the cervical spine due to pain; tenderness to palpation in the lumbar spinal vertebral area; myofascial trigger points noted in the lumbar paraspinal muscles bilaterally; moderately limited range of motion of the lumbar spine secondary to pain; tenderness in the parasternal region), and current diagnoses (cervical radiculitis; lumbar radiculitis; bilateral elbow pain; left hip pain; right shoulder pain; chronic pain, other). Treatments to date have included medications, imaging studies, and surgeries. The medical record indicates that medications help control the pain. The treating physician documented a plan of care that included Naproxen and Eszopiclone.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Naproxen 550mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines non-steroidal anti-inflammatory drugs (NSAIDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NON SELECTIVE NSAIDS Page(s): 72.

**Decision rationale:** Naproxen (Naprosyn): delayed release (EC-Naprosyn), as Sodium salt (Anaprox, Anaprox DS, Aleve [otc]) Generic available; extended-release (Naprelan): 375 mg. Different dose strengths and formulations of the drug are not necessarily bioequivalent. Dosing Information: Osteoarthritis or ankylosing spondylitis: Dividing the daily dose into 3 doses versus 2 doses for immediate-release and delayed-release formulations generally does not affect response. Morning and evening doses do not have to be equal in size. The dose may be increased to 1500 mg/day of Naprosyn for limited periods when a higher level of analgesic/anti-inflammatory activity is required (for up to 6 months). Naprosyn or Naprosyn: 250-500 mg PO twice daily. Anaprox: 275-550 mg PO twice daily (total dose may be increased to 1650 mg a day for limited periods). EC-Naprosyn: 375 mg or 500 mg twice daily. The tablet should not be broken, crushed or chewed to maintain integrity of the enteric coating. Naprelan: Two 375 mg tablets (750 mg) PO once daily or two 500 mg tablets (1000 mg) once daily. If required (and a lower dose was tolerated) Naprelan can be increased to 1500 mg once daily for limited periods (when higher analgesia is required). Pain: Naprosyn or Naprosyn: 250-500 mg PO twice daily. The maximum dose on day one should not exceed 1250 mg and 1000 mg on subsequent days. Anaprox: 275-550 mg PO twice daily. The maximum dose on day one should not exceed 1375 mg and 1100 mg on subsequent days. Extended-release Naprelan: Not recommended due to delay in absorption. (Naprelan) There is no documentation of the rationale behind the long-term use of Naproxen. NSAID should be used for the shortest duration and the lowest dose. There is no documentation from the patient file that the provider titrated Naproxen to the lowest effective dose and used it for the shortest period possible. Naproxen was used without clear documentation of its efficacy. Furthermore, there is no documentation that the provider followed the patient for NSAID adverse reactions that are not limited to GI side effect, but also may affect the renal function. Therefore, the request for Naproxen 550 mg #60 is not medically necessary.

**Eszopiclone 2mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Treatment Antidepressants for chronic pain Page(s): 14. Decision based on Non-MTUS Citation Non-Benzodiazepine sedative-hypnotics Benzodiazepine-receptor agonists (<http://worklossdatainstitute.verioiponly.com/odgtwc/pain.htm>).

**Decision rationale:** Lunesta (eszopiclone) is a nonbenzodiazepine hypnotic agent that is a pyrrolopyrazine derivative of the cyclopyrrolone class. According to MTUS guidelines, tricyclic antidepressants are recommended as a first line option in neuropathic pain, especially if pain is accompanied by insomnia, anxiety or depression. According to ODG guidelines, Non-Benzodiazepine sedative-hypnotics (Benzodiazepine-receptor agonists): First-line medications

for insomnia. This class of medications includes Zolpidem (Ambien and Ambien CR), zaleplon (Sonat), and eszopiclone (Lunesta). Benzodiazepine-receptor agonists work by selectively binding to type-1 benzodiazepine receptors in the CNS. All of the benzodiazepine-receptor agonists are schedule IV controlled substances, which means they have potential for abuse and dependency. Eszopiclone (Lunesta) has demonstrated reduced sleep latency and sleep maintenance. (Morin, 2007) The only benzodiazepine-receptor agonist FDA approved for use longer than 35 days. Lunesta could be used as an option to treat insomnia; however it should not be used for a long-term without periodic evaluation of its need. The provider has to further characterize the patient insomnia (primary versus secondary) and its relation to the primary patient pain syndrome. The provider did not document the use of non pharmacologic treatment for the patient sleep issue. Therefore, the prescription of Eszopiclone 2mg #60 is not medically necessary