

<b>Case Number:</b>	CM15-0118166		
<b>Date Assigned:</b>	06/26/2015	<b>Date of Injury:</b>	07/01/2004
<b>Decision Date:</b>	07/28/2015	<b>UR Denial Date:</b>	06/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/18/2015

### 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  
 Certification(s)/Specialty: Family Practice

### 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 sustained an industrial injury on July 1, 2004. She has reported pain in the cervical spine and has been diagnosed with status post anterior cervical discectomy and fusion C3-C5 and lumbar discopathy. Treatment has included medications, medical imaging, Physical therapy, activity modification, chiropractic care, acupuncture, and injection. There was a well healed surgical scar to the cervical spine. There was pain with terminal motion. Lumbar spine noted there was muscle from the mid to distal lumbar segments. Seated nerve root test was positive. There was pain with terminal motion. There was tingling and numbness in the lateral thigh, anterolateral leg and foot, and posterior leg and lateral foot. The treatment request included Prevacid and eszopiclone.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**120 Prevacid 30mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitors (PPIs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, Gastrointestinal Symptoms & Cardiovascular Risk Page(s): 68-69.

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of proton pump inhibitors (PPIs) including Prevacid. In general, PPIs are used to lower the risk of an adverse gastrointestinal event (such as a GI bleed or ulcer) in a patient deemed at risk. These MTUS guidelines state the following: Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (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). 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 (200 g 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 naproxen plus low-dose aspirin plus a PPI. In this case, there is no evidence that this patient is at intermediate or high-risk for a gastrointestinal event. For example, the patient is not over 65 years of age and there is no evidence of a GI bleed or ulcer. For this reason, a PPI such as Prevacid is not medically necessary.

### **30 Eszopiclone 1mg: 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 (Chronic).

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

**Decision rationale:** The Official Disability Guidelines comment on the use of pharmacologic agents, including Eszopiclone, in the treatment of insomnia. Overall, these guidelines recommend that treatment be based on the etiology. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. The specific component of insomnia should be addressed: (a) Sleep onset; (b) Sleep maintenance; (c) Sleep quality; & (d) Next-day functioning. There are four main categories of pharmacologic treatment: (1) Benzodiazepines; (2) Non-benzodiazepines; (3) Melatonin & melatonin receptor agonists; & (4) Over-the-counter medications. The majority of studies have only evaluated short-term treatment (i.e., 4 weeks) of insomnia; therefore, more studies are necessary to evaluate the efficacy and safety of treatments

for long-term treatment of insomnia. In 2007, the FDA requested that manufacturers of all sedative-hypnotic drugs strengthen product labeling regarding risks (i.e., severe allergic reactions and complex sleep-related behaviors, such as sleep driving). It is recommended that treatments for insomnia should reduce time to sleep onset, improve sleep maintenance, avoid residual effects and increase next day functioning. In this case, there is insufficient documentation that the patient underwent an evaluation for the underlying cause of the sleep disturbance. Also, the records indicate that Eszopiclone is being used as a long-term treatment strategy for this patient's insomnia. The above stated guidelines do not support long-term use of these medications. For these reasons, Eszopiclone is not considered as a medically necessary treatment.