

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

[Date notice sent to all parties]:

06/23/2014

IRO CASE #:

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Lexapro 20mg
#30 refills: 2**

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR
OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

Board Certified Anesthesiology

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained an injury on xx/xx/xx. No specific mechanism of injury was noted. The patient was initially treated for carpal tunnel syndrome as well as ulnar nerve entrapment. The patient did have bilateral carpal tunnel releases completed in April and October of 2010. It appears that the patient has been followed for a diagnosis of CRPS. Per clinical report from 02/01/13, the patient also had multiple positive responses for moderate/severe reactive depression and anxiety secondary to chronic pain. Medications have included the use of Hydrocodone, Gabapentin, Metaxalone, Amitriptyline, and over the counter anti-inflammatories. The patient was started on Cymbalta 30mg daily to be titrated up to 60mg daily as of this evaluation. The patient was also placed on Clonazepam and prescribed Lyrica 50mg. Follow up on 08/20/13 noted a continued depressed

affect and mood. The patient did report substantial improvement with the combined use of Cymbalta and Lyrica. The patient was receiving samples of Lexapro in addition to Cymbalta and Lyrica. This was being done to address both reactive depression and neuropathic pain. The patient did undergo a bilateral sympathetic blockade utilizing a cervical epidural approach on 10/20/13. This did provide substantial relief of the patient's neuropathic symptoms. As of 11/06/13, the patient reported a lower severity of depression symptoms. Further sympathetic blockades were recommended. As of 04/01/14, the patient reported continuing improvement with further sympathetic blocks in the cervical spine. As of this visit, the patient was utilizing 3 Hydrocodone per day at 7.5mg. The patient was able to continue with both Gabapentin and Lyrica. The patient was utilizing Lexapro in the morning as well as Amitriptyline at night. Further injection therapy was recommended at this evaluation. Follow up on 04/30/14 noted an increase in the patient's bilateral symptoms, right side worse than left. Physical examination noted marked hyperesthesia and allodynia in the upper extremities, right side worse than left at the palms. Medication refills included Gabapentin, Amitriptyline, and Norco. The patient was given additional samples of Cymbalta until Lexapro could be filled. Further recommendations for sympathetic blockades were noted. Follow up on 06/02/14 again noted severe CRPS findings on physical examination. The patient continued to be recommended for sympathetic blocks. Lyrica, Amitriptyline, and Hydrocodone were continued at this visit.

The requested Lexapro 20mg, quantity 30 with 2 refills was denied by utilization review on 05/16/14 as this medication was not specifically indicated to treat chronic regional pain syndrome and the use of SSRI antidepressants for chronic pain was noted to be controversial based on controlled trials. There was no evidence of any ongoing psychosocial issues to support the use of this medication.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The patient has been followed for a diagnosis of CRPS that has been medically refractory. The patient continued to report significant symptoms despite multiple sympathetic blockades. The patient did report temporary relief from the blockades only. In review of clinical reports, the patient had substantial relief with the combined use of SNRI antidepressants such as Cymbalta as well as an anticonvulsant, Lyrica. It is noted that the patient was provided some samples of Lexapro in 2013 to address a depression component of the patient's chronic pain. Per guidelines, SNRI antidepressants can be utilized to address depression symptoms related to chronic pain; however, there is limited evidence in the clinical literature supporting the use of an SNRI antidepressant to directly treat chronic regional pain syndrome or chronic pain. In this case, it is unclear what if any functional benefit was obtained with the use of Lexapro as compared to the previous use of Cymbalta. There is no clear evidence of failure of 1st line medications to

address neuropathic pain such as Lyrica or Tricyclic/SNRI antidepressants. No supportive psychological evaluations were submitted for review. Given the overall limited evidence regarding the efficacy of Lexapro in this case, it is this reviewer's opinion that medical necessity for the request is not established.

IRO REVIEWER REPORT TEMPLATE -WC

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Antidepressants for chronic pain

Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. ([Feuerstein, 1997](#)) ([Perrot, 2006](#)) Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. ([Saarto-Cochrane, 2005](#)) Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Side effects, including excessive sedation (especially that which would affect work performance) should be assessed. (Additional side effects are listed below for each specific drug.) It is recommended that these outcome measurements should be initiated at one week of treatment with a recommended trial of at least 4 weeks. The optimal duration of treatment is not known because most double-blind trials have been of short duration (6-12 weeks). It has been suggested that if pain is in remission for 3-6 months, a gradual tapering of anti-depressants may be undertaken. ([Perrot, 2006](#)) ([Schnitzer, 2004](#)) ([Lin-JAMA, 2003](#)) ([Salerno, 2002](#)) ([Moulin, 2001](#)) ([Fishbain, 2000](#)) ([Taylor, 2004](#)) ([Gijssman, 2004](#)) ([Jick-JAMA, 2004](#)) ([Barbui, 2004](#)) ([Asnis, 2004](#)) ([Stein, 2003](#)) ([Pollack, 2003](#)) ([Ticknor, 2004](#)) ([Staiger, 2003](#)) Long-term effectiveness of anti-depressants has not been established. ([Wong, 2007](#)) The effect of this class of medication in combination with other classes of drugs has not been well researched. ([Finnerup, 2005](#)) The "[number needed to treat](#)" (NNT) methodology (calculated as the reciprocal value of the response rate on active and placebo) has been used to calculate efficacy of the different classes of antidepressants. ([Sindrup, 2005](#)) See also the [Stress/Mental Chapter](#): Antidepressants for the treatment of depression. Also see Comorbid psychiatric disorders.

Specifically studied underlying pain etiologies: (also see below for

specific drugs)

Neuropathic pain: Recommended (tricyclic antidepressants) as a first-line option, especially if pain is accompanied by insomnia, anxiety, or depression. ([Saarto-Cochrane, 2007](#)) ([ICSI, 2007](#)) Other recent reviews recommended both tricyclic antidepressants and SNRIs (i.e. duloxetine and venlafaxine) as first line options. ([Dworkin, 2007](#)) ([Finnerup, 2007](#))

Non-neuropathic pain: Recommended as an option in depressed patients, but effectiveness is limited. Non-neuropathic pain is generally treated with analgesics and anti-inflammatories. In guidelines for painful rheumatic conditions recommended by Perrot, it was suggested that antidepressants may be prescribed as analgesics in non-depressed patients, with the first-line choice being tricyclics initiated at a low dose, increasing to a maximally tolerated dose. ([Perrot, 2006](#))

Specific studied disease states

Fibromyalgia: There have been 25 controlled trials that have studied the use of antidepressants for fibromyalgia, including 3 meta-analyses. Except for good results found with duloxetine and fibromyalgia ([Arnold, 2007](#)), the results generally show limited effectiveness on only a minority of patients for this condition, and most of these studies evaluated tricyclics. ([Perrot, 2006](#)) ([Moulin, 2001](#)) A review of two double blind, placebo controlled trials concluded that duloxetine was safe and effective in women with fibromyalgia for up to 12 weeks (with long-term studies needed). ([Arnold, 2007](#)) There appears to be a large placebo effect of this class of medications in treatment of this condition. ([Saarto-Cochrane, 2007](#)) Another review indicated that there is strong evidence that amitriptyline is effective for fibromyalgia; more information is needed regarding the role of SNRIs and SSRIs, so tricyclics may also be used for the treatment of fibromyalgia. ([Goldenberg, 2007](#)) Compared with placebo, the SNRIs duloxetine (Cymbalta) and milnacipran (Savella) are slightly more likely to reduce pain in patients with fibromyalgia, according to a new Cochrane meta-analysis, but they are not superior in terms of reducing fatigue and sleep problems or in improving quality of life, and they appear to cause more adverse effects. ([Häuser, 2013](#))

Low Back Pain: Chronic: A systematic review indicated that tricyclic antidepressants have demonstrated a small to moderate effect on chronic low back pain (short-term pain relief), but the effect on function is unclear. This effect appeared to be based on inhibition of norepinephrine reuptake. SSRIs have not been shown to be effective for low back pain (there was not a significant difference between SSRIs and placebo) and SNRIs have not been evaluated for this condition. ([Chou, 2007](#)) Reviews that have studied the treatment of low back pain with tricyclic antidepressants found them to be slightly more effective than placebo for the relief of pain. A non-statistically significant improvement was also noted in improvement of functioning. SSRIs do not appear to be beneficial. ([Perrot, 2006](#)) Acute: Not routinely recommended. ([Chou, 2007](#))

Radiculopathy: Antidepressants are an option, but there are no specific medications that have been proven in high quality studies to be efficacious for treatment of lumbosacral radiculopathy. ([Dworkin, 2007](#))

Osteoarthritis: No studies have specifically studied the use of antidepressants to treat pain from osteoarthritis. ([Perrot, 2006](#)) In depressed patients with osteoarthritis, improving depression symptoms was found to decrease pain and improve functional status. ([Lin-JAMA, 2003](#))

Antidepressant discontinuation: Nearly all classes of antidepressants have been linked to discontinuation reactions that are distinct from recurrence or relapse of underlying psychiatric pathology. It does appear that discontinuation reactions can occur regardless of the particular indication for use. The most common research involves discontinuation of serotonin-reuptake inhibitors (Serotonin-discontinuation syndrome).

Symptoms: Symptoms of discontinuation vary between classes of antidepressants, and between different drugs in the classes. These may include changes in mental/psychological status (confusion, restlessness, agitation, anxiety, worsening of mood, panic attacks, dysphoria, manic symptoms, and decreased level of consciousness), neurological changes (tremor, rigidity, clonus, myoclonus, hyperreflexia, ataxia, and rigidity), autonomic changes (diaphoresis, shivering, mydriasis, nausea and diarrhea), and changes in vital signs (tachycardia, hypertension, hyperthermia, and tachypnea). Commonly patients describe both psychological and somatic symptoms (the latter described as flu-like, with or without gastrointestinal physical symptoms). Symptoms are thought to occur in at least 20% to 25% of patients upon discontinuing of serotonin-reuptake inhibitors (with reports of at least 50% with drugs with shorter-half lives such as paroxetine or venlafaxine). Symptoms tend to emerge within 2 to 5 days with a usual duration of 1 to 2 weeks. The primary risk factors for this reaction include use of antidepressants with shorter half-lives, longer duration of treatment, and abrupt discontinuation.

Differentiation from depression relapse or recurrence: Differentiating factors include looking for symptoms that are more likely to occur with discontinuation reaction (dizziness, electric shock-like sensations, “rushing” sensations, headache and nausea) as well as observing for rapid reversal of symptoms (complete resolution within 1 to 2 weeks of the taper/discontinuation is less likely to be due to depression). Later onset of symptoms (after at least two to three weeks of discontinuation/tapering) or prolonged symptoms (3 weeks or greater) are more commonly associated with a relapse of psychiatric pathology or another intercurrent disease. See also [Weaning of medications](#) (antidepressants) in the Mental Chapter for more information and references.

SPECIFIC ANTIDEPRESSANTS:

Selective serotonin reuptake inhibitors (SSRIs), a class of antidepressants that inhibit serotonin reuptake without action on noradrenaline, are controversial based on controlled trials. ([Finnerup, 2005](#)) ([Saarto-Cochrane, 2005](#)) It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain. ([Namaka, 2004](#)) More information is needed regarding the role of SSRIs and pain.

Side Effects: Bleeding: An association has been found between the use of SSRI antidepressants and gastrointestinal bleeding. This risk is increased with the concomitant use of ASA or NSAIDs. It is suggested that the increased risk for GI bleeding be discussed with patients that have other risks for GI bleeding. An association with increased intraoperative blood loss has also been found with SSRI use. (Movig, 2003) A treatment option for those at risk for bleeding includes switching to an antidepressant with a lower degree of inhibition of serotonin reuptake (Intermediate reuptake: venlafaxine, amitriptyline, imipramine, citalopram; Low reuptake: desipramine, doxepin, trazodone, bupropion, mirtazapine). SSRIs with the highest degree of inhibition of serotonin reuptake include paroxetine, sertraline, and fluoxetine. ([Looper, 2007](#))