

<b>Case Number:</b>	CM14-0191015		
<b>Date Assigned:</b>	11/24/2014	<b>Date of Injury:</b>	02/13/2006
<b>Decision Date:</b>	01/22/2015	<b>UR Denial Date:</b>	11/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/17/2014

### 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 Psychiatrist (MD), has a subspecialty in Geriatric Psychiatry 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:

Records reviewed include 794 pages of medical and administrative records. The injured worker is a 51 year old male whose date of injury is 02/13/2006. The primary diagnosis is depressive disorder NEC. This occurred during the course of his occupation as an orchard sprayer which also involved seeding and fertilization, often lifting heavy bags. While driving rigs with constant vibration and at consistent speeds of 6.5-7 mph he would hit a significant bump every 60 feet, noting that one of the rigs had no springs. He currently suffers from chronic neck and low back pain radiating into the lower extremities with weakness, and severe headaches. The patient relates that his balance is poor, feeling unsure of the position of his feet without actually looking at them, and he has sustained a number of falls. He ambulates with a walker. He is status post cervical decompression and fusion. He has undergone multiple surgeries, and related that he has received benefit from aqua therapy. He has anxiety and depression manifested by psychomotor agitation, hopelessness, helplessness, and crying episodes. He was started on Cymbalta in 2010 for neuropathic pain, the added benefit of which is that it is also an antidepressant. On 10/24/14 a report by [REDACTED] (psychiatrist) indicated that the patient continues to have feelings of depression, crying spells, worry, decreased sleep, decreased appetite, psychomotor agitation, and weight loss. He denied suicidal ideation. Medications included Cymbalta, gabapentin, Lunesta, Lyrica, Oxycontin, Tizanidine (muscle relaxant), Nuedexta, trazodone (for sleep) and Valium.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Valium 10mg #45:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** The patient has been on Valium since at least 08/13. Taper was first recommended in a review of 08/05/14, then again on 09/08/14, and again on 10/06/14. If these schedules have been followed then the Valium has presumably been discontinued at this point. A more appropriate treatment for anxiety disorder is an antidepressant, which is being addressed separately. Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. (Baillargeon, 2003) (Ashton, 2005). As such the Valium 10mg #45 is not medically necessary.

**Brintellix 10mg #30:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 388. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental illness and stress

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress, antidepressants for treatment of MDD (major depressive disorder)

**Decision rationale:** The patient has been experiencing ongoing depression and anxiety. He has been prescribed Cymbalta since 2010, which was started for neuropathy. It is an antidepressant of the SNRI class. He is also taking trazodone for sleep, which is of the class SAR. He shows residual symptoms of depression and may benefit from the addition of an SSRI. Brintellix is an SSRI, a class of antidepressants considered to be first line agents in the treatment of major depressive disorder due to their efficacy and less severe side effects. CA-MTUS 2009 is silent regarding Brintellix. The guideline was ODG, Mental Illness & Stress, and Antidepressants for treatment of MDD (major depressive disorder). Recommended for initial treatment of presentations of Major Depressive Disorder (MDD) those are moderate, severe, or psychotic, unless electroconvulsive therapy is part of the treatment plan. Not recommended for mild symptoms. Professional standards defer somewhat to patient preference, allowing for a treatment plan for mild to moderate MDD to potentially exclude antidepressant medication in favor of psychotherapy if the patient favors such an approach. (American Psychiatric Association, 2006) A randomized controlled trial has indicated that the patient's smoking status is a credible factor that can be considered in the treatment plan. Specifically, antidepressant medication

(fluoxetine/Prozac) has been found to compromise the success of smoking cessation efforts. (Spring, 2007) Consequently, if the patient is attempting to quit smoking, that effort causes anti-depressant medication to be a less attractive treatment option than standards typically indicate (this consideration will be most relevant to presentations of MDD which are mild to moderate in current severity). Drug selection criteria. The American Psychiatric Association has published the following considerations regarding the various types of anti-depressant medications: (1) many treatment plans start with a category of medication called selective serotonin reuptake inhibitors (SSRIs), because of demonstrated effectiveness and less severe side effects. As such Brintellix 10mg #30 is medically necessary.