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| <b>Case Number:</b>   | CM13-0042253 |                              |            |
| <b>Date Assigned:</b> | 12/27/2013   | <b>Date of Injury:</b>       | 03/09/2005 |
| <b>Decision Date:</b> | 02/18/2014   | <b>UR Denial Date:</b>       | 10/01/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/18/2013 |

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Emergency Medicine and is licensed to practice in New York. 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 physician 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:

The patient is a 50-year-old male with complaints of persistent headache after electrical injury on March 9, 2005. Diagnoses included post traumatic headache, pseudoseizures, R/O occipital neuralgia. Numerous tests performed by a neurologist and epileptologist did not reveal neuro-electrical activity as the cause for his seizures. Treatment included ice/heat, injections, chiropractic care, acupuncture, and medication. The patient received a right greater and lesser occipital nerve block under ultrasound guidance on October 3, 2013. The patient received pain relief for two weeks. The patient then returned but was not as severe. Requests for authorization for right supraorbital nerve block with ultrasound and for right occipital nerve block with ultrasound guidance were submitted on August 5, 2013. Request for right occipital nerve block with ultrasound guidance was partially certified to right occipital nerve block ultrasound without guidance.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right supraorbital nerve block with ultrasound in office:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWG; ODG Treatment; Integrated Treatment/Disability Duration Guidelines neck and Upper Back (Acute & Chronic)(updated 05-14-13).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Clinical Anatomy for Medical Students by Richard S. Snell, Second Edition pages 637, 642

**Decision rationale:** The supraorbital nerve, a branch of the ophthalmic division of the trigeminal nerve, winds around the superior orbital margin and ascends over the forehead. It divides into lateral and medial branches, supplying skin and conjunctiva on the medial part of the eyelid and the skin of the forehead. There was no tenderness on palpation of the supraorbital nerve. Chronic Pain Medical Treatment Guidelines and Official Disability Guidelines do not comment on supraorbital nerve block. The lack of information does not allow determination for medical necessity and safety.

**Right occipital nerve block with ultrasound partially in office certified to right occipital nerve block without ultrasound in office:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWG; ODG Treatment; Integrated Treatment/Disability Duration Guidelines neck and Upper Back (Acute & Chronic)(updated 05-14-13).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck, Greater occipital nerve block, diagnostic; Greater occipital nerve block, therapeutic and Medical Treatment Guideline or Medical Evidence: UpToDate, Cervicogenic Headache.

**Decision rationale:** Greater occipital nerve blocks (GONB) have been recommended by several organizations for the diagnosis of both occipital neuralgia and cervicogenic headaches. It has been noted that both the International Association for the Study of Pain and World Cervicogenic Headache Society focused on relief of pain by analgesic injection into cervical structures, but there was little to no consensus as to what injection technique should be utilized and lack of convincing clinical trials to aid in this diagnostic methodology. Difficulty arises in that occipital nerve blocks are non-specific. This may result in misidentification of the occipital nerve as the pain generator. In addition, there is no research evaluating the block as a diagnostic tool under controlled conditions (placebo, sham, or other control). An additional problem is that patients with both tension headaches and migraine headaches respond to GONB. In one study comparing patients with cervicogenic headache to patients with tension headaches and migraines, pain relief was found by all three categories of patients (54.5%, 14% and 6%, respectively). Due to the differential response, it has been suggested that GONB may be useful as a diagnostic aid in differentiating between these three headache conditions. Greater occipital nerve blocks are under study for treatment of occipital neuralgia and cervicogenic headaches. There is little evidence that the block provides sustained relief, and if employed, is best used with concomitant therapy modulations. Current reports of success are limited to small, noncontrolled case series. Although short-term improvement has been noted in 50-90% of patients, many studies only report immediate postinjection results with no follow-up period. In addition, there is no gold-standard methodology for injection delivery, nor has the timing or frequency of delivery of injections been researched. Limited duration of effect of local anesthetics appears to be one

factor that limits treatment and there is little research as to the effect of the addition of corticosteroid to the injectate. In this case the procedure was certified without ultrasound guidance. UpToDate on cervicogenic headache states that anesthetic nerve blocks should be performed in blinded fashion when the diagnosis is in doubt. There was no confirmation that occipital neuralgia was the etiology of the headache. Ultrasound guidance was therefore not necessary.