

<b>Case Number:</b>	CM13-0049300		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	01/06/1992
<b>Decision Date:</b>	03/06/2014	<b>UR Denial Date:</b>	11/01/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/07/2013

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Florida. 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 46-year-old female who reported an injury on 01/06/1992. The patient is currently diagnosed with neck pain, cervical spinal stenosis, cervical radiculitis, cervical facet syndrome, and chronic pain. The patient was seen by [REDACTED] on 09/09/2013. The patient reported persistent neck pain. Physical examination revealed painful range of motion, hypersensitivity to light touch, and intact sensation. The patient received temporary relief with a cervical facet blockade at the upper most to mid and lower levels. Treatment recommendations included continuation of current medications as well as authorization for radiofrequency treatment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**A third occipital nerve injection:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Head Chapter, Greater Occipital Nerve Block

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Head Chapter, Greater Occipital Nerve Block

**Decision rationale:** The MTUS/ACOEM Guidelines indicate that invasive techniques have not proven benefit in treating acute neck and upper back symptoms. The Official Disability Guidelines indicate that greater occipital nerve blocks are currently under study for use in treatment of primary headaches. As per the documentation submitted, the patient is currently being treated with medial branch radiofrequency ablation. The medical necessity for performing a third occipital nerve injection has not been established. The patient's physical examination only revealed tenderness to palpation with hypersensitivity. There was no indication of chronic migraines or complaints of persistent headaches. Based on the clinical information received, the request is noncertified.

**Norco 10/325mg #120, with three (3) refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-80,91-94. Decision based on Non-MTUS Citation Opioids, State Medical Boards, the guidelines and the Federation of State Medical Boards Model Guidelines for the Use of Controlled Substances for the Treatment of Pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-82.

**Decision rationale:** The Chronic Pain Guidelines indicate that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessment should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain. Satisfactory response to treatment has not been indicated by a decrease in pain level, increase in function, or improved quality of life. Therefore, ongoing use cannot be determined as medically appropriate. As such, the request is noncertified.