

<b>Case Number:</b>	CM13-0065860		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	09/28/2012
<b>Decision Date:</b>	04/29/2014	<b>UR Denial Date:</b>	11/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/13/2013

### 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 Family Practice 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:

The patient is a 56-year-old male who has a date of injury of 09/28/2012; mode of injury is the patient was hit by another driver that ran a red light. The patient has diagnoses of intractable occipital neuralgia due to closed head injury and cervical spine injury, post-traumatic labyrinthitis causing dizziness and imbalance, history of multiple cough syncope, most likely due to the cervical spine stenosis, chronic myofascial pain syndrome, cervical and thoracolumbar spine, and pain and numbness in bilateral lower extremities due to lumbosacral radiculopathy versus peripheral diabetic neuropathy. After the injury, the patient underwent x-rays and MRI/CT and was advised to undergo surgery to neck, which he declined. MRI of 07/25/2013 was negative. The patient has completed home exercise program and medication. Medical documentation was provided from a 10/28/2013 note that states the patient has frequent headaches in the occipital area and sometimes nausea and vomiting is associated. The patient complains of neck pain that occurs most of the time and is typically 5/10 on a pain scale of 1 to 10 without medication and frequent low back pain. The patient also notes thinking slower and speech is slow, and difficulty with destination when driving vehicle. The patient has noted, due to the pain, that he is having trouble with activities of daily living and completing chores around the house. The patient has a diagnosis of diabetes and takes oral medications for that. The only other medication noted was some type of pain medication; however, the name of the medication was not provided. Exam of the cervical spine revealed flexion to 50 degrees, extension to 30 degrees, right lateral flexion to 40 degrees, left lateral flexion to 30 degrees, right rotation to 70 degrees, and left rotation to 70 degrees. The patient has multiple myofascial trigger points and taut bands noted throughout cervical paraspinal, trapezius, levator scapulae, scalene, and infraspinatus muscles. Strength and cranial nerve examinations were both normal and he had a

positive neck compression test. The patient does complain of persistent headaches and exhaustion.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **RETROSPECTIVE OCCIPITAL NERVE BLOCKS X2 DOS: 10/28/13: 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)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head, Greater occipital nerve block (GONB) Section.

**Decision rationale:** CAMTUS/ACOEM does not address. The patient has diagnoses of intractable occipital neuralgia due to closed head injury and cervical spine injury, post-traumatic labyrinthitis causing dizziness and imbalance, history of multiple cough syncope, most likely due to the cervical spine stenosis, chronic myofascial pain syndrome, cervical and thoracolumbar spine, and pain and numbness in bilateral lower extremities due to lumbosacral radiculopathy versus peripheral diabetic neuropathy. Official Disability Guidelines note, for greater occipital nerve blocks, they are under study for use in treatment of primary headaches. Studies on the use of greater occipital nerve blocks for treatment of migraine and cluster headaches showed conflicting results, and when positive, have found response limited to short term duration. The documentation provided does not show that conservative care has been exhausted along with the guidelines that show little evidence that block provides sustained relief for migraine and cluster headaches. Therefore, the request is non-certified.