

Case Number:	CM14-0003455		
Date Assigned:	01/31/2014	Date of Injury:	11/21/2007
Decision Date:	08/25/2014	UR Denial Date:	12/13/2013
Priority:	Standard	Application Received:	01/08/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Alabama. 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 49 year old female who was injured on 11/21/2007. The mechanism of injury is unknown. Prior treatment history has included right thumb extensor injection, trigger point injections which offered her She also received a cervical spine injections which offered her 75% improvement. Her medications as of Norco, Lunesta, gabapentin, meloxicam, omeprazole, Fioricet, and hydroxyzine. Progress report dated 11/26/2013 states the patient complained of neck pain associated with muscle spasm and severe headaches. She also complains of pain radiating from both left occipital region radiating over the head and to behind her left eye. She stated the pain radiates down the left shoulder and down the left arm into the hand including her left wrist and thumb. On exam, the cervical spine revealed tenderness with 2+ palpable muscle spasm present along the left cervical paraspinal muscles. She has a positive Spurling's sign on the left. Range of motion of the cervical spine revealed flexion to 30 degrees; extension is to 25 degrees; right rotation is 50 degrees; and left rotation is 50 degrees. There is decreased tenderness over the base of the right thumb and over the extensor tendon. Muscle strength is 5/5. Diagnoses are recurrent neck pain with associated headaches with cervical radiculopathy right upper extremity with evidence of 4 mm disc protrusion at C3-C4 and 2 mm disc protrusion at C5-C6 and C6-C7; left occipital neuralgia with history of greater occipital nerve block with improvement in symptoms; cervicogenic headaches; right shoulder pain status post arthroscopic surgery on 07/01/2009; lumbar spine sprain/strain; right lower extremity radicular symptoms and right extensor tendonitis. The patient was recommended a left greater occipital nerve block as the patient has received this before and had improvement in her symptoms over a 3 month span. Prior utilization review dated 12/13/2013 states the request for left greater occipital nerve block, is denied as there is no documented failed first line treatments.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT GREATER OCCIPITAL NERVE BLOCK: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), GREATER OCCIPITAL NERVE BLOCK (GONB).

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).

Decision rationale: The above ODG guidelines state that greater occipital nerve blocks are under study for use in treatment of primary headaches. Studies on the use of greater occipital nerve block for treatment of migraine and cluster headaches show conflicting results, and when positive, have found response limited a short-term duration. These guidelines for occipital nerve blocks are not as defined as other procedural injections. It does appear that the patient has tried other conservative measures including norco, soma, neurontine, fioricet, and individual psychotherapy as included in the note from 5/22/13. Although there are no guidelines as to maintenance or repeat injections for greater occipital nerve blocks, it can be extrapolated from other injections such as epidural steroid injections of what constitutes a successful block. Per ODG guidelines for epidural steroid injections, additional blocks may be supported if the initial block/blocks are given and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks... Per progress note on 11/26/13, the patient underwent a left greater occipital nerve block on May 6, 2013. She noted almost 100% resolution of her symptoms that lasted for approximately three months. This meets the criteria for consideration of repeat block for epidural steroid injections, which has similar medication combinations. This suggests that a repeat block should be considered in this patient that had almost 100% resolution of symptoms that lasted for approximately 3 months. Therefore, based on the above guidelines and criteria as well as the clinical documentation stated above, the request is medically necessary.