Case Number:	CM14-0027865		
Date Assigned:	06/13/2014	**Date of Injury:**	11/18/2013
Decision Date:	08/04/2014	**UR Denial Date:**	02/11/2014
Priority:	Standard	**Application Received:**	03/04/2014

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 Internal Medicine 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:

Patient is an injured worker with complaints of neck pain, resulting from a motor vehicle accident with a date of injury of 11-18-2013. The primary treating physician's progress report (PR-2) for date of exam 01/28/2014 was provided by [redacted]. Subjective complaints: the pain in his neck remains a concern. He describes headaches that emanate from the occiput of the skull. Neck pain is 4/10. Physical Exam: Constitutional: He is well-developed, well-nourished, and in no distress. Right shoulder: He exhibits tenderness (to palpation in distribution of trapezius musculature). He exhibits normal range of motion. Left shoulder: He exhibits tenderness (to palpation in distribution of trapezius musculature). He exhibits normal range of motion. Cervical back: He exhibits tenderness. He exhibits normal range of motion. Motor strength: Normal 5/5. Diagnoses: lumbar spondylosis; left/right trapezius strain; myofascial tender points; occipital headache. CT cervical spine without contrast 11/18/2013 report documented findings and impressions: There is no evidence of cervical spine fracture. Sagittal reconstructed images show no compression deformity or malalignment. No prevertebral soft tissue swelling. There are some mild degenerative changes present. Tiny anterior spur formation at C4, C5, and C6. There is multilevel facet degenerative change. There does not appear to be significant spinal stenosis. No evidence of cervical spine fracture. CT thoracic spine without contrast 11/18/2013 report documented findings and impressions: Alignment of the thoracic vertebra is normal. Disc spaces are uniformly maintained. No evidence of fracture or subluxation is seen. The spinal canal is normal in size and contour. The posterior elements and articular relationships are normal. No evidence of thoracic spine trauma. Consultation note 1/31/2014 by [redacted] documented physical examination of C-spine: Patient does not have tenderness to palpation of the spinous processes. There is no tenderness to palpation of the cervical facets bilaterally. Strength and tone of the cervical paraspinal musculature is increased. There are

trigger points elicited with palpation in the right trapezius muscle belly. There is tenderness to palpation over the Greater Occipital Nerves at the level of the occipital protuberance on the right that does produce concordant pain. There is no tenderness to palpation of supraorbital/supratrochlear nerves bilaterally. Upper Extremity Strength 5/5. Analysis and Plan: Occipital neuralgia, Myositis. Patient has axial neck pain and associated occipital headache. Patient's axial neck pain appears to be myofascial and is localized to the right trapezius muscle belly. Patient's occipital headache appears to be due to entrapment and irritation of the right greater occipital nerve by the overlying myofascial spasm. For treatment of both his myofascial pain and his occipital neuralgia would patient benefit from a series of combined right greater occipital nerve blocks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Series of Combined Right Greater Occipital Nerve Blocks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back, Greater Occipital Nerve Block, Therapeutic.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174-175, 181.

Decision rationale: Medical treatment utilization schedule (MTUS) American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints (Page 174-175) states: Invasive techniques (e.g., needle acupuncture and injection procedures, such as injection of trigger points, facet joints, or corticosteroids, lidocaine, or opioids in the epidural space) have no proven benefit in treating acute neck and upper back symptoms. Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) states that 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. Medical records document that the date of injury was 11-18-2013. The patient was examined on 01/28/2014 and 1/31/2014, which is a time period less than three months. MTUS guidelines require that symptoms have persisted for more than three months. MTUS requires that all criteria are met. A CT of the cervical spine and thoracic spine 11/18/2013 reported no significant pathology. ODG and Work Loss Data Institute guidelines do not recommend greater occipital nerve block. MTUS, ODG, Work Loss Data Institute guidelines and medical records do not support the medical necessity of greater occipital nerve block. Therefore, the request for series of Combined Right Greater Occipital Nerve Blocks is not medically necessary.