

<b>Case Number:</b>	CM15-0044656		
<b>Date Assigned:</b>	03/16/2015	<b>Date of Injury:</b>	01/13/2012
<b>Decision Date:</b>	04/20/2015	<b>UR Denial Date:</b>	02/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/09/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Family Practice

### 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 injured worker is a 46 year old male, who sustained an industrial injury on January 13, 2012. The injured worker was diagnosed as having occipital neuralgia, cervical spondylosis with myelopathy, cervical radicular neuropathy, and shoulder impingement syndrome. The injured worker's treatment included chiropractic, acupuncture, psychotherapy, biofeedback, traction, physical therapy and TENS unit all with moderate relief of pain. He has had an MRI of the back and neck, a CT scan and EMG/NCS. Currently, the injured worker complains of pain in the left neck, left upper extremity, right upper extremity, bilateral lower extremity and the head. He describes the pain as aching, burning, dull, pins and needles, pressure-like, sharp and throbbing. The pain is constant and has been present for three years. The pain interferes with his sleep and he can walk two blocks before stopping due to pain. The pain is relieved with bowel movement, lying down, medications, relaxing, urination and walking. The treatment plan includes C6-7 epidural steroid injection, left greater occipital nerve block, physical therapy and exercise of the left shoulder, gastrointestinal consultation, lidocaine patches and neuropathic compounded cream.

### 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:** 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), Online Edition, Neck.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Head and Neck (Acute and Chronic) Section: Greater Occipital Nerve Block.

**Decision rationale:** The Official Disability Guidelines comment on the use of greater occipital nerve blocks for diagnostic and therapeutic purposes. For diagnostic purposes, the guidelines state the following: Under Study. 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). For therapeutic purposes, the guidelines state the following: 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, non-controlled case series. Although short-term improvement has been noted in 50-90% of patients, many studies only report immediate post-injection 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 request does not specify whether the nerve block is for diagnostic or therapeutic indications. Further, there is insufficient documentation in the medical records to determine whether the patient's symptoms are caused by a left sided occipital neuralgia. Finally, there is insufficient documentation, that first-line therapies have been tried for a presumed neuralgia. For these reasons, a left greater occipital nerve block is not considered as medically necessary.

**Left Cervical Trigger point injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 122.

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of trigger point injections as a treatment modality. These guidelines state the following: Trigger point injections are recommended only for myofascial pain syndrome as indicated

below, with limited lasting value. Not recommended for radicular pain. Trigger point injections with an anesthetic such as bupivacaine are recommended for non-resolving trigger points, but the addition of a corticosteroid is not generally recommended. Not recommended for radicular pain. A trigger point is a discrete focal tenderness located in a palpable taut band of skeletal muscle, which produces a local twitch in response to stimulus to the band. Trigger points may be present in up to 33-50% of the adult population. Myofascial pain syndrome is a regional painful muscle condition with a direct relationship between a specific trigger point and its associated pain region. These injections may occasionally be necessary to maintain function in those with myofascial problems when myofascial trigger points are present on examination. Not recommended for typical back pain or neck pain. Criteria for the use of Trigger point injections: Trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. In this case, there is insufficient documentation in support of the patient having specific trigger points as the underlying cause of chronic pain. Without documentation of trigger points, injections to the cervical region are not recommended. Further, there is insufficient documentation that the patient has received an adequate course of conservative treatment, as indicated in the above cited guidelines. For these reasons, left cervical trigger point injection is not considered as medically necessary.

**Follow up Office Visits, quantity 3:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Section, Office Visits.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Pain/Chronic Section: Office Visits.

**Decision rationale:** The Official Disability Guidelines comment on the use of office visits in the management of patients with chronic pain. Office visits are recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as

certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. In this case, there is insufficient documentation to support the rationale specifically for three follow-up office visits. Per the above cited guidelines, there needs to be documentation in support of the medical necessity for these visits. For this reason, three follow-up office visits are not considered as medically necessary.