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| Case Number: | CM15-0055144 | | |
| Date Assigned: | 03/30/2015 | Date of Injury: | 06/07/2000 |
| Decision Date: | 05/05/2015 | UR Denial Date: | 02/23/2015 |
| Priority: | Standard | Application Received: | 03/23/2015 |

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: New York, Tennessee
 Certification(s)/Specialty: Emergency Medicine

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 64 year old female, who sustained an industrial injury on 6/7/00. She reported headaches. The injured worker was diagnosed as having chronic migraine without aura and intractable migraine without mention of status migrainosus. Treatment to date has included Botox injections and occipital nerve blocks. A computed tomography (CT) scan performed in November 2014 revealed an 8mm left caudate infarct. There were no clinical features of cerebrovascular accident that attributed to the CT scan however. Currently, the injured worker complains of frequent and severe headaches. The treating physician requested authorization for an occipital nerve block, trigeminal nerve block, and trigger point injections. A physician's report noted occipital nerve blocks had been very effective in the past.

IMR ISSUES, DECISIONS AND RATIONALES

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

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), Greater occipital nerve block.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Neck, Greater occipital nerve block, diagnostic; Greater occipital nerve block, therapeutic.

Decision rationale: 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). An additional problem is that patients with both tension headaches and migraine headaches respond to GONB. In one study comparing patients with cervicogenic headache to patients with tension headaches and migraines, pain relief was found by all three categories of patients (54.5%, 14% and 6%, respectively). Due to the differential response, it has been suggested that GONB may be useful as a diagnostic aid in differentiating between these three headache conditions. 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, and if employed, is best used with concomitant therapy modulations. Current reports of success are limited to small, noncontrolled 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 patient has been diagnosed with chronic migraine headache. Documentation in the medical record does not support the diagnosis of occipital neuralgia or cervicogenic headaches. There is no indication for occipital nerve block. The request is not medically necessary.

Trigeminal 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), Greater occipital nerve block.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation UpToDate: Trigeminal neuralgia.

Decision rationale: Trigeminal neuralgia (TN) is characterized by recurrent brief episodes of unilateral electric shock-like pains, abrupt in onset and termination, in the distribution of one or more divisions of the fifth cranial (trigeminal) nerve that are triggered by innocuous stimuli. Pharmacologic therapy is used for initial treatment of most patients with classic TN. If medical therapy is not successful, the patient may be treated with surgical therapy, including neurectomy and nerve bock. In this case, documentation in the medical record does not support the diagnosis

of trigeminal neuralgia. There is no indication for trigeminal nerve block. The request is not medically necessary.

Trigger point injections: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 122.

Decision rationale: Trigger point injections are recommended only for myofascial pain syndrome as indicated below, with limited lasting value. 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. 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. Criteria for use of trigger point injections are as follows: 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, documentation in the medical record does not support the presence of trigger points. Trigger point injection is not indicated and is not medically necessary.