

Case Number:	CM14-0197979		
Date Assigned:	12/08/2014	Date of Injury:	04/24/2003
Decision Date:	01/21/2015	UR Denial Date:	11/21/2014
Priority:	Standard	Application Received:	11/25/2014

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 Occupational 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:

Injured worker is a male with a date of injury 4/24/2003. Per primary treating physician's progress report dated 10/16/2014, the injured worker continues struggling with neck pain and associated headaches. He goes to sleep with headaches and wakes up with headaches. He has mixed headaches: migraine, tension and cervicogenic headaches. Relpax helps to relieve headaches. Tramadol helps with neck pain, but not with headaches. Cervical interventional procedures were denied by the insurance company many times. The injured worker continues exercising and doing yoga. He describes the neck pain as constant, pressure-like and averages 5-6/10 in intensity with radiation to his shoulders. He continues following up with an ophthalmologist. The injured worker has noticed double vision. On examination there is mild tenderness to palpation of neck at the cervical paraspinal muscles along facet joints. Neck range of motion was limited to extension, rotation and lateral bending. He had moderate pain with oblique extension. Manual muscle testing revealed the muscle strength 5/5 throughout bilateral upper extremities. Deep tendon reflexes 2+ at bilateral brachioradialis and 1+ at bilateral biceps and triceps. Diagnoses include 1) chronic pain syndrome 2) displacement of cervical intervertebral disc 3) arthropathy of cervical spine facet joint 4) migraine 5) postconcussion syndrome 6) retinal disorder, status post left eye surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

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 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 chapter, Greater occipital nerve block (GONB) section

Decision rationale: The MTUS Guidelines do not address the use of greater occipital nerve block. Per the ODG, occipital nerve blocks are under study for use in treatment of primary headaches. Studies on the use of greater occipital nerve block (GONB) for treatment of migraine and cluster headaches show conflicting results, and when positive, have found response limited to a short-term duration. The mechanism of action is not understood, nor is there a standardized method of the use of this modality for treatment of primary headaches. A recent study has shown that GONB is not effective for treatment of chronic tension headache. The block may have a role in differentiating between cervicogenic headaches, migraine headaches, and tension-headaches. The request for greater occipital nerve blocks is determined to not be medically necessary.

MBB C3-4-5: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174, 181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck Chapter, Facet joint diagnostic blocks section, Facet joint therapeutic steroid injections

Decision rationale: The MTUS Guidelines do not recommend the use of cervical facet joint injections. The ODG does not recommend the use of cervical facet joint injections for therapeutic purposes. The ODG recommends cervical facet joint diagnostic blocks prior to facet neurotomy (a procedure that is considered "under study"). Diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB). The criteria for the use of diagnostic blocks for facet nerve pain include: 1. one set of diagnostic medial branch blocks is required with a response of 70%. The pain response should be approximately 2 hours for Lidocaine. 2. Limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. 4. No more than 2 joint levels are injected in one session (see above for medial branch block levels). 5. Recommended volume of no more than 0.5 cc of injectate is given to each joint, with recent literature suggesting a volume of 0.25 cc to improve diagnostic accuracy. 6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward. 7. Opioids should not be given as a "sedative" during the procedure. 8. The use of IV sedation may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme

anxiety. 9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control. 10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. 12. It is currently not recommended to perform facet blocks on the same day of treatment as epidural steroid injections or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment. This request for "a first trial of C3, 4, 5 medial branch blocks" appears to be for therapeutic purposes rather than diagnostic purposes, which is not recommended by the MTUS Guidelines and ODG. Additionally, when used for diagnostic purposes, the ODG recommends no more than two joint levels be injected in one session and the procedure be limited to patients with non-radicular cervical pain at no more than two levels bilaterally. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines and ODG.