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| Case Number: | CM15-0010926 | | |
| Date Assigned: | 01/28/2015 | Date of Injury: | 08/06/2012 |
| Decision Date: | 03/30/2015 | UR Denial Date: | 12/23/2014 |
| Priority: | Standard | Application Received: | 01/20/2015 |

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 44 year old female, who sustained an industrial injury on 8/6/12. The injured worker has complaints of chronic back pain. PR2 dated 11/4/14 noted that the injured worker came prior to her scheduled visit was in two more weeks because of increasing neuropathic pain on the right lower limb. She had been tried on gabapentin but had an adverse effect so was switched to lyrica. She reports lyrica is tolerable and provides moderate but not complete relief of her burning and tingling. Work status remained as temporarily totally disabled on orthopedic and psychiatric basis. The documentation noted that she had positive straight leg on the right and that palpation of the lumbar facet reveals pain on both sides at L3-S1 regions. Three was pain noted over the lumbar intervertebral spaces (discs) on palpation. The diagnoses have included radiculopathy, lumbar spine; fibromyalgia/myositis; radiculopathy, cervical; spasm, muscle and pain, lumbar spine. According to the utilization review performed on 12/23/14, the requested Greater occipital nerve block under ultrasound guidance has been non-certified. The ODG, the online version for neck greater occipital nerve blocks, under study for treatment of occipital neuralgia and cervicogenic headaches were used. The rationale for determination noted that there was no objective clinical data presented that supports the presence of cervicogenic headaches that might necessity for the greater occipital nerve block and cannot be established based upon the clinical guidelines and/or clinical data submitted at this time.

IMR ISSUES, DECISIONS AND RATIONALES

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

Greater occipital nerve block under US: 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), Nerve Blocks

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 postinjection 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 documentation in the medical record does not support the diagnosis of occipital neuralgia or cervicogenic headache. Greater occipital nerve block is not indicated. The request should not be authorized.