



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

DATE OF REVIEW: 7-29-09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right occipital nerve block #3 under fluoroscopic guidance 64450, 77003, 77002

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

American Board of Anesthesiology and Pain Medicine Certified

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
 Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Records from DO.
- Records from MD.
- Records from MD.
- Records from MD.
- Records from DO.
- Records from MD.
- Records from MD.
- Records from MD.
- Records from MD.

PATIENT CLINICAL HISTORY [SUMMARY]:

Medical records reflect the claimant sustained a work related injury on xx/xx/xx. On this date, he reported he was sitting in traffic when a car traveling at 60 miles per hour, hit his work truck from behind. The car that hit him was totaled. His truck was bent as well as his frame, and it shattered the rear window. There was no loss of consciousness, but felt the days after the incident, he developed left hip pain. He was treated with medications and was also provided with chiropractic manipulative therapy.

MRI of the lumbar spine dated 2-14-07 showed no disc bulge or herniation. No evidence for impingement upon neural elements. Conus slightly lower than typical at the L2-L3 level. No mass or evidence for tethering.

MRI of the pelvis dated 2-14-07 shows some subtle linear increased signal intensity anterior/superior labrum of the left hip, appreciated on the sagittal sequence. Cannot exclude a labral tear here.

The claimant was evaluated by DO., who felt the claimant had a piriformis syndrome. He recommended formal physical therapy and an intraarticular injection based on possible lateral tear to the hip.

On 5-7-07, an MRI of the cervical spine shows minimal 2 mm posterior bulging of the C4-C5 interspace similar to the previous MRI study. Right uncovertebral joint hypertrophy at C5-C6 which has developed since the previous cervical MRI study dated 9-14-05. Loss of the upper cervical spine curvature.

MRI of the right shoulder dated 5-7-07 shows degenerative hypertrophy of the AC joint. There is degenerative cyst noted within the acromial head. Impingement occurs on the superior surface of the supraspinatus muscle tendon junction. The acromion has a mild type C configuration which contributes to the impingement upon the supraspinatus muscle tendon junction. Small periarticular cyst is noted along the medial inferior aspect of the glenoid fossa.

Follow-up with Dr. on 5-10-07 notes the claimant was having pain in the shoulder and some improved range of motion of his neck. He also points to pain to the left SI joint as well. Dr. recommended physical therapy.

MRI of the thoracic spine shows minimal thoracic spondylosis.

On 7-31-07, the claimant was evaluated by DO., for evaluation of his cervical pain. The claimant reports sharp, burning, throbbing and shooting pain. On exam, the claimant has significant amount and discomfort and pain tenderness on palpation of the neural ridge down to C2-C3, C3-C4, the whole facets on the right side. The evaluator recommended cervical facet injections.

On 8-23-07, the claimant was evaluated by MD., for his low back and periscapular shoulder pain. The evaluator recommended trigger point injections, which was provided.

The claimant was provided with cervical facet injections on the right C2-C3 and C3-C4 on 9-21-07.

On 9-25-07, the claimant underwent 13 myofascial trigger points in multiple muscle groups, levator scapula, rhomboids, trapezius, splenius capitus.

Post the facet injections, the claimant reported his pain decreased 50-60% post he facet injections. The claimant reported he wanted to have some trigger point injections to the lumbar spine. The claimant reported he still had headaches. Therefore, Dr. recommended on 9-25-07 a third occipital nerve injection.

An MRI of the cervical spine dated 11-6-07 was normal. MRI of the thoracic spine was normal. MRI of the lumbar spine shows at L3-L4 level, there is a 1-2 mm generalized

disc bulge and mild disc desiccation. There is no central canal or foraminal stenosis at this level.

A Required Medical Evaluation performed by MD., dated 11-19-07 notes the claimant has no objective evidence of any shoulder injury. The evaluator did not feel that any of his MRI findings were related to the motor vehicle accident. The reports describe degenerative changes. Neither continued treatment nor testing is reasonable or necessary, or related to the accepted injury. There is no objective evidence in the records of any injuries significant enough to result in persistent symptoms at his point. There is no objective evidence of any injury to the shoulder at all.

On 2-8-08, the claimant underwent cervical facet rhizotomy to the medial branch at C2-C3 and C3-C4 facet joints on the right.

On 2-12-08, the claimant reported pain in his low back at L4-L5 with significant amount of grief. Dr. recommended thoracic facet injections. Then he recommended dealing with the low back, and then occipital nerve.

On 2-29-08, the claimant underwent cervical facet rhizotomy and lesioning in the medial branch at C4-C5, C5-C6 and C6-C7 on the right.

On 5-2-08, the claimant underwent cervical facet injections at C2-C3 and C3-C4 on the left.

Follow up with Dr. on 6-5-08 notes the claimant reported 60% improvement post the cervical facet injections. The evaluator reported the claimant wants to proceed with C2-C3, C3-C4 and third occipital blocks on the right.

On 6-10-08, the claimant was evaluated by MD., for his right shoulder. He noted the claimant has had appropriate non-operative treatment without improvement. On exam, the claimant has some mild pain with abduction, but no significant weakness. He has some pain with overhead elevation with a mildly positive impingement sign and positive Hawkins sign. There is some tenderness over the AC joint with some pain in the AC joint with cross arm adduction. He felt it was reasonable to do a diagnostic arthroscopy to treat whatever is found.

On 7-16-08, the claimant underwent C2-C3 and C3-C4 facet injections on the right.

On 9-1-08, the claimant was evaluated by MD. He noted the claimant's primary pain now is in his right shoulder. On exam, the claimant has pain with cross body adduction. He has a positive Neer, positive Hawkins, positive Yergason's, positive Speed and positive drop arm test. The evaluator discussed right shoulder arthroscopy with the claimant.

On 9-30-08, the claimant underwent extensive repair of the superior labrum, extensive repair of the Bankart lesion, bursectomy, subacromial decompression and chondroplasty.

On 10-6-08, a CT scan of the lumbar spine shows lower lumbar spondylosis with mild to moderate multilevel neural foraminal narrowing. No high-grade central spinal stenosis.

On 10-7-08, a CT scan of the head shows stable left parietal vascular malformation. No evidence of acute hemorrhage.

The claimant began a course of postoperative physical therapy at Select physical therapy on 11-6-08.

The claimant was seen by Dr. on 11-11-08 and noted the claimant continues with low back, shoulders, thoracic spine, hips and neck pain. Medications were reviewed. The evaluator recommended an MR arthrography of the left hip.

MRI of the left hip post arthrogram dated 11-24-08 shows mild to moderate hyaline cartilage wear of the acetabulum especially anterosuperiorly and superiorly with small subchondral cystic changes. There is also a prominent flap tear of the acetabular labrum in the anterosuperior to posterosuperior aspects extending range of motion approximately 1 o'clock position to 10 o'clock position. There is either a small 6 mm paralabral cyst versus less likely a small cyst within a tiny osteophyte related to chondromalacia just lateral to the anterosuperior labrum. Mild degenerative arthrosis and chondromalacia of the right hip joint.

On 11-26-08, the claimant underwent lumbar facet injections at L4-L5 and L5-S1 bilaterally.

Follow-up with Dr. notes reports pain to the right side of the neck. The evaluator talked to the claimant as to what area he wanted to work on. The claimant reported his neck, as the injection has helped his neck 75-80% relief. The low back is doing okay. He wants to proceed with cervical rhizotomy.

On 1-7-09, the claimant underwent cervical facet rhizotomy and lesioning in the medial branch at C2-C3 and C3-C4 facet joints.

An MRI of the right shoulder post arthrogram dated 1-9-09 shows no evidence of rotator cuff tear. There is fluid in the subacromial/subdeltoid bursa consistent with bursitis. Small sublabral foramen at the 1 o'clock position. There may be mild chondromalacia or a small fissure of the hyaline cartilage at 1 o'clock position. No tear is identified however; post surgical changes are seen involving the labrum.

X-rays of the hips was negative.

Follow-up with Dr. dated 2-10-09 notes the claimant has had significant relief with the cervical rhizotomy and facet injections. The claimant wanted to see if he could have rhizotomies done inferior at C4-C5, C5-C6 and C6-C7. The claimant underwent seven trigger point injections at levator scapula, rhomboids, and trapezius.

On 3-27-09, the claimant underwent cervical facet rhizotomy and lesioning in the medial branch at C4-C5, C5-C6 and C6-C7 facet joints.

Follow-up with Dr. notes the claimant now is having low back pain that is centralized. The evaluator noted the claimant has had facet injections in December 2008 with good relief. Now that we have finished with the neck, the claimant can have rhizotomies at the lumbar spine.

On 4-29-09, the claimant underwent lumbar facet injected at L3-L4 and L4-L5 on the right and left.

Follow-up with Dr. dated 5-26-09 notes the claimant has different complaints. He noted 80% pain relief for 4-5 days. The claimant started having headache, which started in the posterior aspect and went over the right in the occipital area in the front. The claimant did not want to go to the ER because of the wait. He just put an ice pack on it. The evaluator recommended a third occipital nerve block and if that works, then do a rhizotomy. Secondary, try rhizotomy in the low back.

MD., performed a Utilization review. It was his opinion that this male has had multiple injections including lumbar facet injections, cervical rhizotomy and cervical facet injections, trigger point injections and prior occipital nerve blocks. The most recent May 26, 2009 note reports this is a request for the third occipital nerve block. Records do not reflect how the claimant responded to prior blocks. Records do not reflect the specific indication for these. Per ODG Greater occipital nerve block, is therapeutic. Under study for treatment of occipital neuralgia and cervicogenic headaches. Reviewer comments: The clinician does not discuss the clinical necessity for this greater occipital nerve block. The reviewer discussed the case with Dr. The patient has apparently had multiple prior blocks including RF at two levels. The results of which are not discussed in the medical records. He was unable to provide additional clinical information to warrant the request.

An Appeal Utilization review performed by DO., notes non-certification. Documentation lacks evidence to support clinical indications for this block. Documentation is not clear on how long the claimant has had this headache and any previous attempts at treatment.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

This patient has had multiple cervical facet/medial branch blocks without significant benefit. The third occipital nerve is blocked at the level of the C23 facet joint. This patient has had blocks at the C23 facet joint level on 9/21/07, 6/5/08, and 7/16/08. The

patient even had RFL at C23 Rt on 2/8/08 without documented significant relief. It does not appear that the source of the headaches are of C23 Rt origin. I do not find evidence in the medical records justifying pursuing additional third occipital nerve blocks. Therefore, non-certification is provided for the requested right occipital nerve block #3 under fluoroscopic guidance 64450, 77003, 77002.

ODG-TWC, last update 2-17-09 Occupational Disorders of the Head – Occipital Nerve block: 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. (Ashkenazi, 2005) (Inan, 2001) (Vincent, 1998) (Afridi, 2006) 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. (Leinisch, 2005) The block may have a role in differentiating between cervicogenic headaches, migraine headaches, and tension-headaches. (Bovim, 1992).

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**