

AccuReview
An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: March 13, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left Occipital Nerve Block Injection 64405, 13301, J3490

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

This physician is Board Certified in Occupational Medicine with over 34 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

12-07-05: MRI Cervical Spine w/o Contrast interpreted by DC
12-07-05: MRI Shoulder w/o Contrast interpreted by DC
09-20-08: EMG/NCS of the upper extremity performed by MD
09-01-09: Office Visit by MD
09-08-09: Office Visit by, MD
09-30-09: Office Visit by, MD
10-15-09: Office Visit by, MD
04-15-10: Office Visit by, MD
07-06-10: Office Visit by, MD
07-15-10: Office Visit by, MD
09-24-10: Office Visit by, MD
10-11-10: Office Visit by, MD
10-21-10: Office Visit by, MD
11-11-10: Office Visit by, MD
12-20-10: Office Visit by, MD
02-28-11: Office Visit by, MD

03-14-11: Office Visit by, MD
07-14-11: Office Visit by , MD
09-22-11: Office Visit by, MD
01-16-12: Office Visit by, MD
01-23-12: UR performed by, MD
02-02-12: Office Visit by, MD
02-13-12: UR performed by, MD
02-20-12: Office Visit by , MD

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx.xx.xx.

12-07-05: MRI Cervical Spine w/o Contrast interpreted by DC. Conclusions: 1. Mild end plate spondylosis C2-C3, C3-C4, and C4-C5. No neurocompression. 2. Mild annular bulging C4-C5. No neurocompression. 3. Moderate intervertebral osteochondrosis and spondylosis at CC5-C6 and C6-C7 creating mild central stenosis and bilateral neuroforaminal stenosis. The neuroforaminal stenosis is most pronounced at C5-C6 on the right.

12-07-05: MRI Shoulder w/o Contrast interpreted by DC. Conclusions: 1. Full thickness grade III tear of the supraspinatus/rotator cuff with associated retraction measuring approximately 1 cm. 2. Marked hypertrophy of the acromioclavicular joint and hypertrophy of the coracoacromial ligament compressing the supraspinatus. 3. Type II SLAP tear. 4. Posterior inferior labral tear suspicious of a partial sankart lesion with associated dorsal subluxation of the humeral head. Clinical correlation advised for glenohumeral instability. 5. Effusion and distension of the glenohumeral joint. 6. Tenosynovitis long head of the biceps tendon.

09-20-08: EMG/NCS of the upper extremity performed by MD. No interpretation provided.

09-01-09: Office Visit by MD. It was reported that the claimant had complaints of posterior neck inferiorly bilaterally (right worse than left) pain with no referral of pain to other locations. Diagnosis: Spondylosis; cervical w/o myelopathy, and myofascial. Dr. performed right cervical facet injection. The claimant was prescribed Baclogen 10 mg and Methylin 5 mg, Methadone HCL 10 mg was refilled, and Methocarbamol was discontinued.

09-08-09: Office Visit by MD. It was reported that the claimant received 50% improvement with the right cervical facet injection. In 2007 he received a left cervical facet injection which helped 75%. On physical examination there was tenderness off midline only on the right in the trapezius-moderate. Active ROM: flexion was mildly restricted due to posterior neck pain bilaterally, and extension was moderately restricted due to posterior neck pain bilaterally. Muscle strength and sensory exam was normal. Plan: Cervical RFTC, single level and add'l level were to be scheduled.

09-30-09: Office Visit by, MD. Left cervical RFTC single level and add'l level was performed.

10-15-09: Office Visit by, MD. It was reported the claimant received 75% improvement of left sided cervical pain with left cervical RFTC. He was able to reduce methadone by half. He was helping with work and now mainly had right neck pain with severe muscle cramps that awaken him at night. He was prescribed Methadone HCL 10 mg, 1 TAB BID, and Baclofen and Methadone HCL 3 TAB BID was discontinued. Plan: Proceed with right cervical RFTC

04-15-10: Office Visit by, MD for a 6 month follow-up. It was reported the claimant had an increase in neck pain. Dr. performed trigger point injections.

07-06-10: Office Visit by, MD. The claimant still complained of an increase of neck pain. Plan: Schedule right cervical RFTC.

09-24-10: Office Visit by, MD. A right cervical RFTC was performed. The claimant was prescribed Naproxen Sodium.

10-11-10: Office Visit by, MD. It was reported the claimant received 75% improvement overall with the right cervical facet RFTC. Plan: Schedule left cervical RFTC.

11-11-10: Office Visit by, MD. A left sided cervical RFTC was performed.

12-20-10: Office Visit by, MD. It was reported he had increased left sided neck pain. Dr. performed trigger point injections in the neck, bilateral trapezius and rhomboids. The claimant was prescribed Mobic and his Methadone HCL, Modafinil, and Robaxin was refilled.

02-28-11: Office Visit by, MD. It was reported that claimant had posterior neck pain in the suboccipital area on the left and inferiorly bilaterally (left worse than right); trapezius area bilaterally (left worse than right); and headaches. On physical examination there was tenderness off midline only on the left in the trapezius, moderate to severe. Active ROM: flexion was asymptomatic; extension was restricted due to suboccipital pain on the left only, severe, posterior neck pain bilaterally, severe. Muscle strength was intact. The claimant was prescribed Percocet and Naproxen and Norco were discontinued. Plan: A left occipital nerve block.

03-14-11: Office Visit by, MD. A left sided occipital nerve block was performed. Plan: Schedule trigger point injections.

07-14-11: Office Visit by, MD. It was reported the claimant was having an increase in posterior neck pain inferiorly on the right and trapezius are on the right. Pain was referred to headache which had been a recurring problem. Plan: Repeat right C3, C4 median branch RFTC.

09-22-11: Office Visit by, MD. It was reported that the claimant had cervical pain in the posterior neck in the suboccipital area on the left; and bilaterally (equal on both sides); and inferiorly bilaterally (equal on both sides); trapezius area bilaterally (equal on both sides); and headaches. Plan: Bilateral cervical C3, C4 median branch RFTC.

01-16-12: Office Visit by, MD. The claimant reported "neck causing pain down entire left side of body". He had cervical pain in the posterior neck in the suboccipital area on the left; and inferiorly on the left; trapezius area on the left; and headaches. On physical examination there was tenderness off midline bilaterally in an asymmetric distribution on the left in the trapezius, moderate-severe. Active ROM: flexion was restricted due to suboccipital pain on the left only that was moderate and posterior neck pain bilaterally that was moderate. Extension was restricted due to suboccipital pain bilaterally, moderate. Rotation was restricted due to moderate posterior neck pain bilaterally. Muscle strength was intact. Diagnosis: Occipital Neuralgia. Plan: Proceed with left occipital nerve block, too soon to repeat RFTC, may consider more distal cervical facets down the line.

01-23-12: UR performed by, MD. Rationale for Denial: Claimant has chronic cervical degenerative hypertrophic facet changes from C4-7 with neurocompressive effects on the neural foramen. There is no medical indication for occipital nerve blocks for his clinical condition.

02-02-12: Office Visit by, MD. The claimant reported an increase in severe flare-up of left occipital pain. He was prescribed Percocet and told to double up on his medications. Plan: Schedule left occipital nerve block.

02-13-12: UR performed by, MD. Rationale for Denial: The request is not medically supported. Peer review guidelines indicate that greater occipital nerve block is under study for the use in treatments primarily of migraine and cluster headaches. The claimant has more suboccipital tenderness with no documentation of ongoing headaches. A recent study has shown that greater occipital nerve block is not effective of treatment of chronic tension headache. The claimant has objective evidence of degenerative disc disease of the cervical spine; therefore this block would not be indicated to rule out cervicogenic pathology.

02-20-12: Office Visit by MD. It was reported the claimant's neck pain was controlled but ongoing headaches in the left suboccipital area were daily. The headaches were described in the bilateral occipital scalp (left worse than right). At onset it is a burning sensation. The severity of the headaches are much more severe and he rated the pain level a 9. The claimant also indicated the occurrence of the headaches are more frequent. A left occipital nerve block was recommended.

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

This is a claimant who sustained an on the job injury to the cervical spine on xx/xx/xx. An MRI showed cervical stenosis with foraminal stenosis at C5-6. He was treated with spinal injections with 75% success. In 2011 he received an occipital injection for headache with only partial relief, and documentation in the notes dated 1/16/12 state that he complains of cervical pain that radiates down the entire left side of the body, neck to the left trapezius.

ODG states/greater occipital nerve:"under study. Greater occipital nerve blocks (GONB) have been recommended by several organizations for the diagnosis of both occipital neuralgia and cervicogenic headaches." and that "Difficulty arises that occipital nerve blocks are non-specific. This may result in misidentification of the occipital nerve generator. (Biondi, 2005) (Leone, 1998) (Aetna, 2006)."

Reviewer comments:

As the claimants symptoms are not anatomically specific to the occipital region and the requested procedure is "under study", this procedure is not likely to be curative. Additionally seven years have passed since the DOI therefore it is unlikely that the present symptoms are causally related to the original industrial injury. These symptoms may be due to diseases of aging. For these reasons I am not endorsing this request as it is unlikely to produce the desired outcome and it is not supported by the ODG. The previous adverse determinations are upheld.

ODG:

Greater occipital nerve block, diagnostic	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. (Haldeman, 2001) Difficulty arises in that occipital nerve blocks are non-specific. This may result in misidentification of the occipital nerve as the pain generator. (Biondi, 2005) (Leone, 1998) (Aetna, 2006) In addition, there is no research evaluating the block as a diagnostic tool under controlled conditions (placebo, sham, or other control). (Bogduk, 2004) 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. (Bovim, 1992) See also Greater occipital nerve block, therapeutic and the Head Chapter .
Greater occipital nerve block, therapeutic	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. (Biondi, 2005) 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. (Haldeman, 2001) (Inan, 2001) (Vincent, 1998) 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. (Bogduk, 2004) See also Greater occipital nerve block, diagnostic and the Head Chapter .
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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)**