

Health Decisions, Inc.

6601 CR 1022

Joshua, TX 76058

P 972-800-0641

F 888-349-9735

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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Greater Occipital Nerve Block CPT-64405, J3301

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

American Board Certified Anesthesiologist with 6 years' 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 medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a male injured while driving a company vehicle. The date of injury is listed as xx/xx/xx when the patient was driving and was rear ended by a drunk driver running from the law at 120 MPH. Patient presented to the ER 16 hours after MVA with back pain. The patient is still having chronic headaches, neck pain, and left hand tingling and numbness. Patient has completed PT, examined by a neurologist, has a pain mgt doctor. This is a request is for treatment in the form of an occipital nerve block.

11/08/14: ED visit notes: Pt reports that the pain in his thoracic spine is gradually worsening over the last 16 hours and is associated with an MVA. The pain is present in thoracic spine (has history of thoracic fusion at T7 and T8 and this is where his pack pain is.) The quality of pain is described as stabbing. The pain is moderate. The pain does not radiate. The symptoms are aggravated by bending, twisting, and certain positions. Symptoms are relieved by nothing. The pain is the same all of the time. Pt was negative for tingling, weakness, numbness, headaches, and paresthesia. All other symptoms were reviewed and are negative. Normal neuro examination and normal gait. On exam he exhibits tenderness on back and record reports that there were sores all across back worse over t-spine. Patient was given prescriptions for Ultram and Flexeril and discharged home. In

ED record XR spine thoracic 2 views impression: Although no discrete acute traumatic abnormality is identified osteopenia somewhat limits evaluation. There is sufficient clinical concern; CT evaluation is recommended for further characterization. Remote inter body spacer placement at T7-T8, with a intervertebral space narrowing.

12/16/14: Office visit notes: Pt presents with back pain and left hand pain. He reports that the symptoms started 1 month ago. Pain is aggravated by movement, lifting and activity and pain is constant. Pt reports that nothing makes the pain better and that he has tried stretching and meds. Pt reports that he was seeing Neurology for the numbness in his left hand but symptoms have not improved. He also reports having headaches at least 4 times a week. These are new since the injury. Headaches last 3-6 hours posterior neck to vertex. He is able to sleep and is taking Tylenol #4 which helps. Neck is still sore from injury with no improvement. Traction and TENS helps at PT but TENS was denied by carrier. Plans EMG/NCV LUE. On Flexeril TIW and Tyl #4 as needed which is 3-4 times a week up to 2 times per day. Not working since MVA. Past Medical History: ADD, Anxiety, Diabetes Mellitus, Hyperlipidemia, HTN, Joint pains L&R knees, MVA, Sleep apnea, WC MVA whiplash-C strain, HA, LA hand numbness. Musculoskeletal Assessment: Gait compensated cervical spine- tender, ROM; moderate pain with motion. Thoracic spine-tenderness. Knee- Left; tenderness. Fair squat. Neck ROM poor. Muscle spasm parasp bilat. LT hand with mild weakness and decreased sensory from wrist to fingers. Lumbar spine normal. Shoulder left and right normal, knee right normal no edema. Return to clinic in 1 month or prn. Use of injured areas as tolerated.

12/17/14: EMG of the Left upper extremity: Impression: EMG of the left upper extremity showed mildly decreased recruitment in the first dorsal interosseous muscle. There were no fibrillations or positive waves. Normal motor nerve conductions of the left median nerve. Motor nerve conductions of the left ulnar nerve showed low normal CMAP amplitudes with slightly decreased conduction velocities both below and above the elbow. Delayed F-waves of the left median and ulnar nerves. Absent sensory response of the left ulnar nerve. Mildly delayed latencies of the left median nerve at the palm and second digit. Normal sensory nerve conductions of the left superficial radial nerve. Conclusion: Left sensory-motor ulnar nerve lesions with axonal pathology which could not be localized on this study. Mild left sensory median nerve lesion at the wrist.

12/30/14: Physical Therapy Progress note: Pt complains of difficulty gripping and carrying due to left hand tingling and numbness, unable to work, not driving as much, was driving 10-14 hours a day. Severity of pain 5/10. Reports C-Spine is stiff. Assessment: Tolerance- Pt progressing fairly towards goals demonstrating mild improvement in cervical ROM and flexibility. Pts grip strength remains unchanged for LUE with patient report of glove like tingling distribution in L hand. Patient unable to return to work secondary to unable to meet job driving demands. Plan: Continue with rehab program and advance as tolerated.

01/07/15: Physical Therapy Re-Evaluation: Pt still complains of pain and constant pins and needle sensation in the L hand with "locking up" feeling in L thumb periodically throughout the day 3-5 times. Assessment: This patient requires skilled physical therapy to address the problems identified, and to achieve the individualized patient goals. The patient is educated regarding their diagnosis, prognosis, related pathology and plan of care. The expected length of this episode of skilled therapy services required to address the patient's condition is estimated to be 3 visits. Pt was referred to physical therapy with a chief complaint of neck pain after a car accident at work as a truck driver. Pt has not demonstrated significant improvement in his pain level or in his ability to grip for prolonged periods secondary to ongoing numbness in his left hand. Continues to demo increased pain on palpation along c-spine; moderate soft tissue restriction in the s-spine secondary to spasm and decreased flexibility. Demo good strength on BUE but continues to report inability to work due to pain and headaches. Pt minimal progress with PT necessitates return for further follow/up alternative treatment. May benefit from further imaging. We will continue for the remainder of his current authorized visits (3 more visits) after which pt will be discharged and return for further follow up.

01/13/15: Office visit notes: Pt presents to office with back and left hand pain. This is a follow up visit from injury 2 months ago. Symptoms related to injury remain unchanged. Assessment: Gait compensated. C-spine tender ROM: mild pain with motion. Thoracic spine tenderness. Rotation, squat same. Fair ROM neck and back. Fair ROM neck. Spasms parasp muscles neck and upper back. Pt continues with neck, occipital and posterior HA. No improvements. Some spasm consistent with whiplash. Refractory nature is less expected.

01/14/15: Physical Therapy Discharge Summary, DPT: No further skilled care is necessary for the client and he is discharged from PT. Progress has plateaued and further alternative treatment is needed.

01/14/15: Office visit notes: Pt now presents for a follow up. He is still having a lot of headaches which start in his neck and radiate up to his head. They are associated with photophobia, phonophobia, nausea and vomiting and are typically alleviated by going to sleep but not always. He has been doing physical therapy. A TENS unit does help and they requested one through WC but it was denied. There is a particular spot on his left upper neck which seems to trigger the headaches. Pt was started on amitriptyline and was referred to a hand specialist. Follow up in 4 weeks.

01/21/15: History and Physical notes: Musculoskeletal inspection spinal process tender to palpation- C5 no facet tenderness, no pain with facet loading, straight leg raise test negative, and no incision. Spinal ROM is normal. Brachial neuritis or radiculitis. Displacement of cervical intervertebral disc without myelopathy. complains of neck pain with left sided radicular symptoms. There are neurological deficit noted on his physical exam, however he has no imaging at this time. I will order a cervical MRI to try and determine the etiology of his symptoms. Pending the results we can discuss his treatment options. Previous treatments include two

months of physical therapy and home exercises with no benefit. He is currently taking Naproxen, Flexeril and Tylenol #4 for pain control although he reports no improvement with medications. He had previous trigger point injections which provided no relief.

01/26/15: Office visit notes: No acute injuries noted immediately. Prior to the crash he had no symptoms in the left hand. Since the crash he reports constant paresthesia in the left hand w/ associated with weakness. He does report headaches and neck pain. EDX= axonal lesion of the ulnar non localized w/ mild median neuropathy at the wrist. His symptoms have not been improving. I recommended decompression of the nerves under gen anes. He has an appt with pain management physician, and MRI neck pending. The risks, benefits and alternatives of surgery were discussed with the patient. His questions were addressed and he will think about it. I would also like to see the results of the MRI of the neck. Assessment and Plan: Carpal Tunnel Syndrome and Lesion of the ulnar nerve.

02/02/15: MRI C-Spine W/O CONT: Impression: Central/ left paracentral protrusion at C5-C6 minimally deforming the left C6 ventral outlet at 4mm. Given capacious canal no significant central stenosis is seen. There is however significant left sided foraminal narrowing. Central protrusion of 3-4mm at C3-C4 There is no significant deformity of the C4 ventral outlets or compromise of the canal centrally. Foraminal narrowing however noted, left greater than right as noted above. Right paracentral/ right far lateral protrusion of 3mm C6-C7 without definite deformity of the C6 ventral outlet. Spondylosis with very small degree of right foraminal narrowing.

02/10/15: Office visit notes: Physical exam: Cervical spine- tender, ROM mild pain with motion Thoracic spine tenderness. LT parasp neck pain and LT trap pain. ROM shoulder ok. LB ok, squats ok. ROM neck and back fair. LT hand decreased sensory. Gait normal. Mild pain in LT neck and trap. No changes. LT hand/UE with EMG findings of nerve ailment. Finally has seen pain mgt and hand specialist in addition to neurology.

02/11/15: Progress and Orders Note: Motor: This is follow up visit to discuss results of MRI of the neck. Pt states that the pain is in the neck as well as headaches. He also complains of numbness/ tingling in the left hand. The pt states the pain 8/10. He describes it constant, shooting, pins and needles, and numbness, the pain is worsened with nothing. The pain is improved with using a TENS unit and traction in therapy. Musculoskeletal inspection spinal process tender to palpation- C5 no facet tenderness, no pain with facet loading, straight leg raise test negative, and no incision. Normal gait able to stand without difficulty. imaging was reviewed today. The MRI shows multilevel disc herniations with left foraminal narrowing at C3-4 and C5-6 along with mild right foraminal narrowing at C6-7. I will proceed with a cervical ESI at C6-7.

02/11/15: Office visit notes: Initial resistance is 5/5 throughout, but tends to give way due to pain in the left upper extremity. Normal tone. No abnormal

movements. Sensory: decreased sensation and pinprick in the left hand to the wrist. Intact to light touch, vibration and proprioception. cervical spine MRI does show multilevel degenerative disease, including a disc bulge at C5-6 which appears to slightly deform the left C6 nerve root. This does not mean that it is symptomatic, and as the EMG/NCS showed definite lesions of the ulnar and medial nerve. I would recommend that he proceed with the surgery. would prefer to wait however.

02/23/15: Procedure note for cervical ESI: Pre-Operative diagnosis: Cervical HNP without Myelopathy; Radiculitis and Cervical Radiculitis. Post-Operative diagnosis- same. Procedure was completed at Vanguard Surgical Center. Pt tolerated the procedure well and was discharged.

03/05/15: Operative note: Pre-operative diagnosis: Left ulnar nerve lesion at the elbow, Left carpal tunnel syndrome. Post-operative diagnosis: Left ulnar nerve lesion at the elbow, Left carpal tunnel syndrome. Procedures: Left ulnar nerve decompression at the elbow, in situ. Left open carpal tunnel release. Findings: Complete decompression of the ulnar nerve at the elbow which protection of MABC nerves. Complete decompression of the medial nerve at the wrist.

03/09/15: Office visit notes: is status post a procedure. He underwent a cervical epidural steroid injection midline C6-7 on 02/23/15. He states 0% improvement patient states that the pain is in the neck with persistent headaches. He also complains or numbness/ tingling in the left hand. The patient states the pain is a 6/10-7/10. He describes it deep, constant, shooting, pins and needles, numbness, and throbbing. The pain is worsening with nothing. The pain is improved with traction. Left upper extremity: Strength deltoid triceps weakness present. Musculoskeletal inspection spinal process tender to palpation- C5 no facet tenderness, no pain with facet loading, straight leg raise test negative, and no incision. Stability: no subluxations present. Spine ROM normal. Plan: Unfortunately the patient did not get any improvement with the procedure. Given this I will send them for a surgical evaluation.

03/10/15: Office visit notes: the symptoms began 4 months ago. The symptoms are reported as being moderate. The symptoms occur daily. Aggravating factors include movement, lifting, and activity. Relieving factors include meds and rest. He states the symptoms are chronic and are poorly controlled. LOV 2/10/15. Has seen, Amitriptyline 50 mg at night. As needed Norco 5 and Flexeril. Trigger point's transient help. Seeing pain mgt. Had ESI on left 2/23/15. No help. No Neck pops and gets acute HA severe. Referred to , ortho surgery. Had nerve surgeries by on March 5th on LT elbow and hand which helped relieve pain and numbness in hand and 4th, 5th fingers. Paresthesia in entire hand better. FU with specialists. PT did not work on neck. No FU with Neurology or Pain Mgt planned. Assessment: Persistent pain LT neck and occiput with radiation into headache. Since LOV, trigger point injections. ESI to neck and surgery for injured LT median and ulnar nerves have been done. The latter has helped the sensory deficits of the LUE 100%. No complaints with LUE now other than post op pain. The ESI and trigger point TX did not help. On meds. Pain mgt has referred to spine surgeon for an

opinion. There is arthroplasty and disc protrusion encroaching significantly on Neural foramen L>R mainly at C5-6 and less C3-4 no LUE radiculopathy noted and no pain or sensory changes in LUE now, postop.

04/06/15: Office visit notes: Main problem now and remains bilat intermittent and unpredictable "popping" in neck which progresses to occipital then vertex HA causing him to stop everything including driving. Home traction of sorts helps. Flexeril helps some. Plan referral to Chiro eval and FU Neurology, Pain Mgt as well. No surgery recommended at this point after eval. Cont. meds amitrip and Flexeril.

04/13/15: Clinic note: Short term goal is to improve in flexibility and mobility. Long term goal is restoration of function. Treatments may consist of interferential electrical stimulation, manual therapy, mechanical traction and therapeutic exercises. Therapeutic exercises will help prevent re-injury and help restore function an initial 12 sessions of therapy is being requested 3-4 times for 4 weeks.

04/15/15: Clinic note: Pt did not exhibit negative side effects at the conclusion of the treatment. More active modalities will be added to the treatment plan in accordance to patient tolerance. Pt complaint today was neck pain, muscle spasms, and intermittent headaches. The pain is sharp and achy and constant but the headaches are intermittent and occur with weekly frequency. Triggered by rotation of the neck. The patient finds relief with inactive and not turning head.

04/24/15: Clinic note: No change in assessment. Pt did not exhibit negative side effects at the conclusion of treatment. More active modalities will be added to the treatment plan in accordance to pt tolerance. Pt should return in a few days for follow up.

05/05/15: Office visit notes: gentle man with a history of chronic neck pain that causes headaches. Was also having numbness in his left hand but recently underwent left carpal tunnel release and ulnar nerve release at the elbow which has helped with the numbness. He complains of posterior neck pain. He states if he turns his head he will sometimes hear a crunch and then has immediate pain and severe headache behind his eyes. He states, "It is like someone hit me between the eyes with a 2x4" No pain down his arms. No problems using his hands. No gait or balance problems. He has had PT and chiropractic treatment, found traction helps. Patient has chronic pain and headaches. I would not recommend any surgical intervention at this time. Follow up with pain management.

05/07/15: Office visit notes: There is no change in the pain. Trial of 8 sessions by chiropractor no help. His own home grown traction setup helps the most. Less "popping" of neck. He has seen spine surgeon who sent him back for pain mgt, possibly ablation into occipital area? This is the main concern. Needs definitive treatment then wait for MMI. Some spasms. Flexeril helps.

05/15/15: UR: Case discussed with designated representative . for the described medical situation, the above noted reference would not support the specific requested to be one of medical necessity. This reference indicates that the requested injection is under study for the treatment of headaches. As such, per criteria set forth by the above noted reference, presently, medical necessity for this specific request is not established, for the described medical situation. This review results in the following determination regarding the treatment being requested: Adverse Determination.

06/04/15: UR: Based on the clinical information provided, the appeal requested for bilateral greater occipital nerve block is not recommended as medically necessary. The initial request was non-certified noting that the reference indicates that the requested injection is under study for the treatment of headaches. There is insufficient information to support a change in determination, and the previous non-certified is upheld. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The Official Disability Guidelines note the greater occipital nerve blocks are under study for use in treatment of primary headaches. This review results in the following determination regarding the treatment being requested: Adverse Determination.

06/09/15: Physical Therapy note: Pt is right hand dominant male who was in MVA accident while driving a truck at work on xx, resulting in neck and back injury as well as nerve compression in left ulnar nerve at elbow and also median nerve at wrist level (carpal tunnel). He underwent left carpal tunnel release and ulnar nerve release at the elbow. He is referred to OT by for eval and treatment—decrease in pain and edema, increased ROM, increase strength, restore function for 1-2 times per week for 4 weeks. Pt reports that he is feeling better than last therapy session and he can tell strength is improving and scar is not as hard in palm. The patient was educated regarding their diagnosis, prognosis, related pathology and plan of care. The patient demonstrated a good understanding of risks, benefits, precautions/ contraindications and prognosis of their skilled rehab program.

06/23/15: Physical Therapy note: Strength has improved in left hand. Scar seems to have also improved. Patient is able to lift crate with 4 gallons full of water (35 total) for 5 trials- floor/ waist/ shoulder height without difficulty. Able to perform lateral pulls down on weight machine at 40# and also using ultra gripper up to 35# for several minutes of repetitive grasp / release tasks. It appears that is an appropriate candidate for discharge to home program. He has grasp, pinch as well as proximal strengthening program for home performance. No further skilled care is necessary and the client is discharged.

06/25/15: Office visit notes: W/C back and left hand. The symptoms began 7 months ago. The symptoms are reported as being moderate. The symptoms occur constantly. Aggravating factors include movement, lifting and activity. Relieving factors include meds and rest. He states the symptoms are chronic and are poorly controlled. LOV 5/7/15. Prior PT only traction helped. 12 visits. Chiro

next, did PT. sent for block. WC denied nerve blocks in occiput. HA's still main problem when neck pops. No better. PT for LT hand and arm finished recently. Hand strength better. FU with hand soon. Neurology not seen for a while. The injury was work related and occurred on xx and symptoms related to injury remain unchanged. The injury is associated with decreased mobility and joint pain. Consult chronic pain but continue pain mgt in case blocks approved for occiput. Re consult neurology to see if TX there are exhausted. His prognosis is poor at this point. Pt is on numerous meds for DM, HTN, Depression, Lipids, ADD, Lasix, and Obesity. No work until cleared by specialists.

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

The initial request that was non-certified is upheld as there is insufficient information to support a change in determination. There is no comprehensive assessment of treatment completed to date or the claimant's response to that treatment. Per ODG, greater occipital nerve blocks are under study for use in treatment of primary headaches and therefore cannot be recommended for use as treatment. Therefore, the request for Greater Occipital Nerve Block CPT-64405, J3301 is denied.

Per ODG: 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](#)) See also the Neck Chapter: [Cervicogenic headache, facet joint neurotomy](#); [Greater occipital nerve block, diagnostic](#); & [Greater occipital nerve block, therapeutic](#).

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)**