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IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Peripheral Nerve Block for Vascular Headache

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

This case was reviewed by a Board Certified Doctor of Physical Medicine and Rehabilitation with over 20 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 medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

XXXX: X-Ray Report interpreted by **XXXX**, DC, CCSST. Cervical Spine: There are no apparent fractures, osseous pathology, or congenital bony abnormalities noted in the c-spine. Loss of the normal cervical lordosis. 40mm of anterior cervical translation. Patient has a break in George's line on the film at C2-C3 and C5-C6 with extension which is indicative of ligament damage and laxity. Thoracic Spine: Loss of disc height and osteophytic changes at: T6-T7, T7-T8, and T8-T9. Lumbar Spine: There is a 7mm pelvic unleveling noted, with the high hip on the right side. A left pelvic translation is visualized on the AP lumbar x-ray. L1 is 37mm anterior to vertical axis line of S1. Disc degeneration is visible at L4-L5 and L5-S1.

XXXX: MRI Lumbar Spine without contrast interpreted by **XXXX**, MD. **Impression:** 1. Edema in the L4-5 interspinous space; correlate for interspinous bursitis/injury. 2. Increased fluid in the L5-S1 facet joint, correlate for active inflammation/ injury. 3. At L4-5 is a broad-based disc herniation measuring up to 5 millimeters in AP dimension with tear of the annulus fibrosus. This impinges on the descending left-sided L5 nerve roots in the left lateral recess and abuts the descending right sided L5 nerve roots in the right lateral recess. There is mild spinal canal stenosis. There is encroachment on bilateral neural foramen, correlate possible dynamic irritation of bilateral exiting L4 nerve roots.

XXXX: MRI Cervical Spine without contrast interpreted by **XXXX**, MD. **Impression:** 1. Straightening of the normal cervical lordosis, which may be seen with muscle spasm. Correlate clinically for muscle spasm. 2. Summary of multilevel changes as follows: At C2-3 there is a 2 millimeter disc herniation with mild spinal canal stenosis. At C3-4 there is a 1-2 millimeter disc herniation with mild spinal canal stenosis. There is mild left greater than right neural foraminal narrowing. At C4-5 there is a 2 millimeter disc herniation and right foraminal disc protrusion with mild spinal canal stenosis. There is moderate right and mild left neural foraminal narrowing. At C5-6 there is a disc herniation superimposed left lateral recess disc protrusion measuring up to 3 millimeters. This

flattens and deforms the left ventral spinal cord with mild spinal canal stenosis. There is moderate left greater than right neural foraminal narrowing. At C6-7 there is a 1 millimeter disc herniation and mild bilateral neural foraminal narrowing. 3. Multilocular thyroid gland, evaluation with ultrasound is recommended if not recently performed.

XXXX: UR performed by **XXXX**, MD. **Rationale for Denial:** The patient doesn't appear to have undergone conservative treatment, which would be necessary before considering any more invasive procedures. The request is therefore not medically necessary.

XXXX: UR performed by **XXXX**, MD. **Rationale for Denial:** The most current physician note provided for my review was from **XXXX**. Will need updated physician note with detailed an objective physical exam findings and details regarding the need for this block. I was unable to discuss with the physician the exact request. Given the lack of current and sufficient clinical information, request is not medically necessary.

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

Denial of request for Peripheral Nerve Blocks for Vascular Headaches is UPHELD/AGREED UPON since there is lack of clinical information regarding trial of conservative treatment including physical therapy, modalities, activity modification, home exercise program, and medications prior to progression to more aggressive, invasive treatment.

Per ODG:

<p>Greater occipital nerve block, diagnostic</p>	<p>Under study.</p> <p>See also Greater occipital nerve block, therapeutic and the Head Chapter.</p> <p>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)</p>
<p>Greater occipital nerve block, therapeutic</p>	<p>Under study for treatment of occipital neuralgia and cervicogenic headaches.</p> <p>See also Greater occipital nerve block, diagnostic and the Head Chapter.</p> <p>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</p>

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](#))

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)**