

Occipital Nerve Blocks and Managed Care: A Review of the Reviewers

Case History and Follow-up Submitted by Randolph W. Evans, MD

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(*Headache*. 2001;41:990-991)

Denial of an insurance claim for occipital nerve blocks raises questions about utilization review by insurance companies and peer reviewers. Who reviews the reviewers?

CLINICAL HISTORY

A 40-year-old man presented with a 3-week history of right-sided more than left nuchal-occipital and parietal throbbing pain of moderate intensity daily on an intermittent basis and lasting for several hours. There was no associated nausea, light or noise sensitivity, aura, fever, or other systemic symptoms. He reported no antecedent history of head or neck trauma. Ibuprofen did not help. There was no prior history of significant headaches. Past medical history was unremarkable.

Examination revealed marked tenderness to palpation bilaterally (right more than left) over the mid superior nuchal line, with radiating pain which reproduced the patient's headache. Neurologic examination was normal. Bilateral greater occipital nerve blocks were performed with 3 cc each of 1% lidocaine to each side. Complete relief of the headaches resulted and they did not recur.

A charge for the occipital nerve blocks was submitted to the patient's insurance company (one of the nation's largest) and subsequently was denied. In the written denial was the following: "Injection of local

anesthetics and/or steroids are not medically necessary for treatment of occipital neuralgia that is of unknown etiology and not attributable to organic disease of the head and neck, because their effectiveness has not been clearly demonstrated in peer-reviewed medical literature. Therefore, benefits are not available under the plan." I appealed and sent material from peer-reviewed journals and from Adams, Victor, and Ropper's *Principles of Neurology* which spoke to the benefits of occipital nerve blocks.

The insurance company medical director replied: "The medical staff and an independent physician consultant, board certified in neurology, reviewed the medical documentation submitted for the final appeal. This review confirms our initial determination that the occipital nerve block injections, CPT code 64405, do not meet our medical necessity guidelines.

In order for a test or service to be covered under the plan, it must be commonly and customarily recognized as an acceptable and appropriate test or service for the diagnosis or treatment of a specified condition according to general medical standards of the medical community at large.

. . . medical necessity guidelines are based on valid evidence published in the peer reviewed medical literature to support the effectiveness of the test or service in question. A literature search did not reveal the occipital nerve block injections to be proven effective in the treatment of occipital neuralgia or unknown origin. . . the medical necessity for occipital nerve block injections has not been established. Therefore, benefits are not available under the plan.

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Please be advised that a final appeal has been completed on the case. There are no further appeal steps available with us.”

Question.—Do you agree with this decision by the insurance company’s medical director and the peer reviewer?

EXPERT COMMENTARY

The patient presented with the recent onset of headaches which possessed some features of migraine, cluster, and occipital neuralgia, but not features sufficient to fulfill the criteria required for diagnosis of any of these according to the International Headache Society classification system. He was treated (appropriately) with bilateral occipital nerve blocks, the only treatment, in my experience, which can provide acute and lasting relief and is devoid of side effects. Medical practitioners have been performing occipital nerve blocks for the treatment of intractable headaches for at least the past 6 decades (because of the dramatic relief such treatment can provide). They have tended to refer to the headache so treated as *occipital neuralgia* because of the marked tenderness to palpation (which accompanies the headache) in the region of the greater occipital nerve. In so doing, they made a clinical sign into a disease entity.

Hadden¹ advocated a role for the occipital nerve in the generation of headache by noting “strangely, in several cases, one or two injections of procaine hydrochloride have been effective in giving relief from headache for several years with no recurrence to date.” Parelson² reported that tenderness of the greater occipital nerve was the most common sign accompanying chronic headaches, regardless of etiology, and he suggested occipital nerve injections for those with a benign source. Gawel and Rothbart³ found that a number of patients with migraine who exhibited sensitivity around the greater occipital nerve, failed to respond to standard migraine therapy but responded to steroid-containing occipital blocks. Knox and Mustonen⁴ found injection of local anesthetic an “extremely effective treatment,” theorizing that migraine itself may initiate greater occipital neuralgia. Anthony^{5,6} revealed that injection of methyl-

prednisolone around the greater occipital nerve was effective in aborting an attack and conferring prophylaxis for the great majority of patients with migraine, cluster headache, and occipital neuralgia. Caputi and Firetto⁷ found occipital nerve blocks to be effective in the acute and chronic treatment of migraine. Yannakakis found occipital nerve blocks containing a steroid to be effective acute and chronic therapy for a group of patients with intractable lateralized headaches (mostly migrainous).⁸

Based on the reports summarized above, common sense, and my continuing personal experience, I disagree with the insurance company’s medical director and the peer reviewer.

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FOLLOW-UP

This insurance company has denied every claim submitted for occipital nerve blocks in other patients. The medical director and/or his representative was invited to rebut this article but declined.