



Southwestern Forensic  
Associates, Inc.

## REVIEWER'S REPORT

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Diagnostic lumbar facet injections at L1/L2 and L2/L3 bilaterally

### DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in practice of Pain Management full time since 1993

### REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

The ODG criteria for diagnostic facet injections have been met.

### INFORMATION PROVIDED FOR REVIEW:

1. Denial information
2. MRI scan, 2/20/10
3. Records from Dr., 4/5/10

### INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This was injured on the job. MRI scan showed some degenerative changes with no nerve impingement. He has persistent back pain with no leg pain and no evidence of radiculopathy. Physical examination and medications have been utilized, but pain persists.

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

The ODG criteria for diagnostic lumbar facet injections include the following:

1. One set of injections should be performed in response of greater than 70%. It should be limited to patients with low back pain that is nonradicular at no more than two levels bilaterally. This has been met.
2. There should be documentation of failure of conservative treatment. This has been met.
3. No more than two levels are injected. This criterion is met.
4. There should be no previous fusion. This has been met.
5. Diagnostic facet blocks should not be performed in patients with which surgical procedure is anticipated. This criterion is met.

It is reasonable and necessary under ODG criteria to perform the requested bilateral diagnostic facet injections.

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

*(Check any of the following that were used in the course of your review.)*

- 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)