PACIFIC NORTHWEST PAIN SPECIALISTS

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PRIOR AUTHORIZATION REQUEST

Lumbar Epidural Steroid Injection

PATIENT INFORMATION

Patient Name: Daniel R. Morrison

Date of Birth: July 18, 1969 (Age 55)

Insurance Member ID: REGENCE-OR-5847392

Group Number: GRP-TECH-991

Requesting Physician: Patricia Lee, MD - Pain Management

Provider NPI: 8473926501

Request Date: October 8, 2024

REQUESTED PROCEDURE

CPT Code: 64483 - Transforaminal epidural injection, lumbar, single level

Procedure Details: Fluoroscopy-guided left L5 transforaminal epidural steroid injection with contrast confirmation

Anatomical Level: Left L5 nerve root (L5-S1 level)

Medication: Dexamethasone 8mg (non-particulate corticosteroid) + Lidocaine 1%

Proposed Date: October 25, 2024

DIAGNOSIS

Primary Diagnosis: M51.16 - Intervertebral disc disorder with radiculopathy, lumbar region

Secondary Diagnosis: M54.16 - Radiculopathy, lumbar region (left L5 distribution)

Tertiary Diagnosis: M51.26 - Other intervertebral disc displacement, lumbar region

CLINICAL PRESENTATION

Chief Complaint: Left leg pain and numbness

History of Present Illness:
Mr. Morrison is a 55-year-old software development manager presenting with recurrent left lower extremity radicular symptoms. He reports experiencing left leg pain radiating from the lower back down the posterior thigh, lateral calf, and into the dorsum of the left foot. Pain is described as sharp and burning in quality, rated 7/10 on the numeric rating scale. Associated symptoms include numbness and paresthesias affecting the left lateral calf and dorsal foot, consistent with L5 dermatomal distribution.

The patient states his current episode began approximately 10 weeks ago following a weekend of yard work involving heavy lifting and bending. He describes the onset as gradual over 2-3 days, progressively worsening over the subsequent weeks. Pain is aggravated by prolonged sitting (>30 minutes), forward bending, and transitions from sitting to standing. Symptoms are partially relieved by lying supine and walking for short distances.

Functional Impact:

- Difficulty sitting through work meetings (requires frequent position changes)
- Disrupted sleep 4-5 nights per week
- Unable to participate in usual recreational activities (cycling, hiking)
- Difficulty with prolonged driving
- Reduced productivity at work due to pain and need for frequent breaks

Pain Assessment:

- **Numeric Rating Scale (NRS):** 7/10 average pain, 9/10 at worst
- **Oswestry Disability Index (ODI):** 46% (Moderate Disability) - Assessed October 6, 2024
- Pain significantly interferes with work, sleep, and recreation

TREATMENT HISTORY

Conservative Treatment - Current Episode (10 weeks):

Treatment	Duration	Response

NSAIDs (Ibuprofen 600mg TID)	10 weeks	Mild reduction in inflammation, minimal impact on radicular pain. Ongoing.
Gabapentin (titrated to 900mg TID)	8 weeks	Moderate improvement in burning pain and paresthesias (~30-40% reduction). No impact on mechanical pain. Continued.
Muscle Relaxants (Cyclobenzaprine 10mg HS)	8 weeks	Improved sleep but no significant impact on daytime symptoms.
Physical Therapy	7 weeks (14 sessions, 2x/week)	McKenzie extension protocol initially, transitioned to core stabilization. Patient reports <25% improvement in symptoms. Currently attending 2x weekly.
Home Exercise Program	7 weeks (ongoing)	Daily compliance with prescribed exercises including prone pressups, pelvic tilts, and lumbar stabilization.
Activity Modification	10 weeks	Modified work setup, avoiding heavy lifting, frequent position changes. Limited improvement.

Prior Pain Management History:

According to the patient's report and partial records from his previous pain management provider (Portland Pain Center, Dr. Mark Stevens), he was being treated for similar symptoms earlier this year. Patient states he had "previous treatment with injections" that provided temporary relief. However, details are somewhat unclear as medical records transfer is incomplete.

Patient's Account of Prior Treatment:

When asked about prior interventional treatments, patient stated: "I had an injection for my back pain earlier this year at my old pain doctor's office. I think it was in March or April. It helped for a while, maybe a couple months, but then the pain came back. That's why I'm here now."

Documentation from Previous Provider:

Partial records received from Portland Pain Center show the following references:

- **Chart note dated February 28, 2024:** "Patient reports good response to prior injection performed at outside facility. Pain improved from 8/10 to 3/10. Benefit lasted approximately 2 months before gradual symptom recurrence."
- **Chart note dated May 15, 2024:** "Patient states previous ESI provided good but temporary relief. Now experiencing recurrent symptoms. Will continue conservative management at this time."

- **Progress note dated July 22, 2024:** "Discussed treatment options including repeat epidural injection. Patient considering options."

PHYSICAL EXAMINATION

Examination Date: October 6, 2024

Vital Signs: BP 136/82, HR 72, BMI 27.4, Temperature 98.4°F

General Appearance: Well-appearing male in mild distress with position changes

Lumbar Spine:

- Inspection: Normal alignment, no visible deformity
- Palpation: Tenderness left paraspinal L5-S1, no midline tenderness
- Range of Motion:
  - Flexion: To mid-shin level (~75°), reproduces left leg pain
  - Extension: 20° (limited by left leg symptoms)
  - Lateral bending: Symmetric, mildly limited

Neurological Examination:

Assessment	Left Lower Extremity	Right Lower Extremity
Motor Strength		
Hip Flexion (L2-L3)	5/5	5/5
Knee Extension (L4)	5/5	5/5
Ankle Dorsiflexion (L4-L5)	4+/5 (mildly weak)	5/5
Great Toe Extension (L5)	4/5 (weak)	5/5
Ankle Plantarflexion (S1)	5/5	5/5
Sensory		
Light Touch	Decreased lateral calf and dorsal foot (L5)	Intact all dermatomes
Reflexes		
Patellar (L4)	2+	2+

Achilles (S1)	1+ (diminished)	2+

Special Tests:

- Straight Leg Raise: Positive left at 45° (reproduces radicular pain to foot)
- Crossed Straight Leg Raise: Negative
- Slump Test: Positive left

Examination Impression: Clinical findings consistent with left L5 radiculopathy with objective motor weakness, dermatomal sensory changes, and positive nerve tension signs.

DIAGNOSTIC IMAGING

MRI Lumbar Spine without Contrast
Date: September 18, 2024
Facility: Northwest Imaging Associates
Indication: Left lower extremity radiculopathy

Findings:

- **L4-L5:** Mild degenerative changes, no significant stenosis or herniation
- **L5-S1:** Moderate-sized left posterolateral disc herniation measuring 6mm in anteriorposterior dimension. Disc material extends into left lateral recess with contact and mild displacement of descending left L5 nerve root. Moderate left foraminal narrowing. Right foramen and central canal patent.
- Vertebral body heights and alignment preserved
- No evidence of fracture, infection, or neoplasm

Impression:

1. Left L5-S1 posterolateral disc herniation with left L5 nerve root compression
2. Findings concordant with left L5 radiculopathy on clinical examination

ASSESSMENT & TREATMENT PLAN

Mr. Morrison presents with left L5 radiculopathy secondary to L5-S1 disc herniation with nerve root compression confirmed on MRI. Clinical examination demonstrates objective neurological deficits including motor weakness (EHL 4/5, ankle dorsiflexion 4+/5), dermatomal sensory changes, and positive nerve tension signs. Current symptoms have persisted for 10 weeks despite conservative management including medications, physical therapy, and activity modification.

Patient transferred care from another pain management practice where he was apparently being treated for similar or related symptoms. Based on chart notes from the previous provider, there are references to a "prior injection" that provided temporary benefit, and mentions of "previous ESI" in clinical documentation. However, complete procedural records have not yet been received, and specific details regarding any prior epidural steroid injections (date, location, technique, response, duration of benefit) remain unclear.

Clinical Rationale for Current Request:

Given the documented nerve root compression on MRI, concordant clinical findings, failure of 10 weeks of current conservative management, and significant functional limitation (ODI 46%), a fluoroscopy-guided transforaminal epidural steroid injection is clinically indicated. The procedure will target the symptomatic left L5 nerve root at the L5-S1 level to reduce inflammation and provide pain relief.

Proposed Procedure:

- Fluoroscopy-guided left L5 transforaminal epidural steroid injection
- Contrast injection (Omnipaque 240) to confirm epidural spread and exclude vascular uptake
- Dexamethasone 8mg (non-particulate) mixed with lidocaine 1%
- Real-time fluoroscopic guidance in AP and lateral views Post-
- procedure monitoring for 30 minutes

Concurrent Treatment Plan:

- Continue physical therapy 2x weekly
- Maintain current medication regimen (gabapentin, NSAIDs)
- Continue home exercise program
- Follow-up 2 weeks post-procedure to assess response
- Outcomes assessment using NRS and ODI

Expected Outcomes: Anticipate 50-70% pain reduction, improvement in functional capacity, and enhanced ability to participate in physical therapy and activities of daily living.

Respectfully Submitted,

Patricia Lee, MD

Board Certified Anesthesiology and Pain Medicine

Pacific Northwest Pain Specialists

Electronically Signed: October 8, 2024 at 9:45 AM PDT

Provider NPI: 8473926501

For Questions or Additional Information:

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