MIDWESTERN SPINE & ORTHOPEDIC ASSOCIATES

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PRIOR AUTHORIZATION REQUEST

Epidural Steroid Injection Procedure

PATIENT & PROVIDER INFORMATION

Patient Name: Jennifer M. Anderson

Date of Birth: April 7, 1975 (Age 49)

Insurance Member ID: CIGNA-MN-6283947

Group Number: GRP-TECH-882

Requesting Physician: Rachel Kim, MD - Physical Medicine & Rehabilitation

Provider NPI: 7362849501

Authorization Request Date: July 16, 2024

REQUESTED PROCEDURE

CPT Code: 62323 - Injection(s), diagnostic or therapeutic substance(s), interlaminar epidural or subarachnoid, lumbar or sacral (caudal)

Procedure Type: Fluoroscopy-guided lumbar interlaminar epidural steroid injection

Anatomical Level: L4-L5 interlaminar space

Imaging Modality: Fluoroscopic guidance with contrast verification

Medication to be Injected: Dexamethasone 10mg (non-particulate) + Lidocaine 1% 2mL

Proposed Procedure Date: July 30, 2024

DIAGNOSIS INFORMATION

Primary Diagnosis: M54.16 - Radiculopathy, lumbar region

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

Tertiary Diagnosis: M54.5 - Low back pain

CLINICAL PRESENTATION

History of Present Illness:

Ms. Anderson is a 49-year-old software engineer who presents with a 14-week history of progressive left lower extremity radicular symptoms. She reports the onset began in early April 2024 following a weekend gardening project involving extensive bending and lifting. Initially, she experienced only lower back discomfort, but over the subsequent two weeks, pain began radiating into the left buttock and posterior thigh.

The patient describes the pain as sharp and electric in quality, traveling from the left lower back down the posterior aspect of the left thigh, continuing into the lateral calf, and extending to the dorsal aspect of the foot. She reports associated paresthesias described as "pins and needles" affecting the lateral aspect of the left foot and the web space between the great toe and second toe. Patient notes subjective weakness when attempting to walk on her heels with the left foot.

Symptom progression has been gradual but steady. Ms. Anderson reports that symptoms are now present throughout most of the day and significantly impact her ability to sit at her computer workstation for extended periods. She describes needing to stand and walk around every 20-30 minutes due to increased discomfort with prolonged sitting. Sleep

disturbance is reported approximately 4-5 nights per week, with difficulty finding comfortable sleeping positions.

Aggravating Factors: Prolonged sitting (>30 minutes), forward bending, transitioning from sitting to standing, prolonged standing, driving

Relieving Factors: Walking for short distances, lying supine with knees elevated, application of ice to lower back, gentle stretching

Impact on Function: Patient reports significant difficulty maintaining full work productivity due to inability to sit for extended periods. Has modified workstation to alternate between sitting and standing. Unable to participate in usual recreational activities including yoga and hiking. Avoids lifting objects heavier than 10 pounds. Has curtailed social activities due to discomfort with prolonged sitting in restaurants or social venues.

CONSERVATIVE TREATMENT HISTORY

Documentation of Conservative Management - 14 Week Duration

Treatment Modality	Timeline	Clinical Response
Oral Medications		
NSAIDs (Naproxen 500mg BID)	10 weeks	Minimal impact on radicular symptoms. Slight reduction in axial back pain. Continued use.
Gabapentin	8 weeks (Titrated: 300mg daily → 900mg TID)	Moderate improvement in burning/neuropathic component. Paresthesias reduced by approximately 30-40%. No impact on mechanical pain. Ongoing.

Muscle Relaxant (Tizanidine 4mg HS)	6 weeks	Improved sleep quality. Reduced muscle tension. Continued as needed.
Physical Therapy	9 weeks (18 sessions total, 2x per week)	Initial program focused on McKenzie extensionbased exercises. Later transitioned to core stabilization and neural mobilization. Patient reports modest improvement in back pain but minimal change in radicular symptoms. Currently attending 2x weekly.
Home Exercise Program	9 weeks (ongoing)	Daily compliance with prescribed exercises including prone press-ups, pelvic tilts, hamstring stretches, and lumbar stabilization exercises. Patient demonstrates good understanding and technique.
Activity Modification	14 weeks (ongoing)	Modified work setup with sit-stand desk. Avoiding heavy lifting and prolonged bending. Taking frequent position breaks.
Chiropractic Care	4 weeks (8 sessions)	Gentle mobilization and manipulation. Patient reported temporary relief lasting 1-2 days after treatment. Discontinued after 4 weeks due to lack of sustained benefit.

Summary of Conservative Care: Despite 14 weeks of comprehensive, multimodal conservative treatment including appropriate medication management, structured physical therapy program, and activity modification, patient continues to experience significant radicular symptoms with functional limitations. Patient demonstrates good compliance with all recommended treatments and remains motivated to participate in ongoing conservative care.

PHYSICAL EXAMINATION FINDINGS

Date of Examination: July 14, 2024

Vital Signs: Blood Pressure 124/78 mmHg, Heart Rate 70 bpm, Temperature 98.4°F, BMI 26.3

General Appearance: Patient appears well-developed, well-nourished, in no acute distress at rest. Mildly uncomfortable with position changes.

Musculoskeletal Examination - Lumbar Spine:

- Inspection: No visible deformity, normal lumbar lordosis maintained
- Palpation: Mild tenderness left L4-L5 and L5-S1 paraspinal region, no midline tenderness
- Range of Motion:
  - Flexion: To fingertips mid-shin level (approximately 70°), limited by left leg pain
  - Extension: 15° (reproduces left leg symptoms)
  - Lateral bending: Right 25°, Left 20° (left limited by discomfort)
  - Rotation: Symmetric, mildly limited bilaterally

Neurological Examination - Lower Extremities:

Assessment	Left Lower Extremity	Right Lower Extremity
Motor Examination		
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 Examination		
Light Touch	Diminished dorsal foot (L5 distribution)	Intact all dermatomes
Pinprick	Reduced lateral foot and great toe web space	Normal
Reflex Examination		
Patellar (L4)	2+	2+
Achilles (S1)	2+	2+

Special Tests:

- Straight Leg Raise: Positive left at 55° (reproduces radicular symptoms into foot), negative right
- Crossed Straight Leg Raise: Negative bilaterally
- Femoral Nerve Stretch Test: Negative bilaterally
- Slump Test: Positive left (reproduces leg symptoms)

Gait Assessment: Mildly antalgic favoring left leg. Difficulty with heel-walking on left due to weakness. Toe-walking intact bilaterally.

Clinical Impression from Examination: Physical examination findings are consistent with left L5 radiculopathy. Objective findings include diminished motor strength in L5innervated muscles (ankle dorsiflexors, great toe extensors), dermatomal sensory changes, and positive nerve tension signs.

DIAGNOSTIC IMAGING

MRI Lumbar Spine without Contrast

Imaging Date: June 5, 2024
Imaging Facility: Twin Cities Advanced Radiology
Ordering Physician: Dr. Rachel Kim

Technique: Multiplanar, multisequence MRI of lumbar spine using standard protocol including T1-weighted, T2-weighted, and STIR sequences in sagittal and axial planes.

Findings:

- **L3-L4:** Mild posterior disc bulge without herniation. Central canal and neural foramina patent bilaterally. No evidence of nerve root compression. • **L4-L5:** Moderate-sized left posterolateral disc herniation measuring approximately 7mm in anterior-posterior dimension. Disc material extends into left lateral recess with contact and mild displacement of the descending left L5 nerve root. Moderate left foraminal narrowing. Right foramen and central canal remain patent.
- **L5-S1:** Mild degenerative disc disease with preserved disc height. Small central disc bulge without significant stenosis. Neural foramina patent bilaterally.
- Vertebral body heights and signal intensity normal throughout
- No evidence of fracture, infection, or neoplastic process
- Conus medullaris terminates at normal L1 level with normal morphology
- Mild facet arthropathy L4-L5 bilaterally

Impression:

1. Left L4-L5 posterolateral disc herniation with left L5 nerve root compression
2. Mild multilevel lumbar degenerative disc disease
3. Findings concordant with left L5 radiculopathy on clinical examination

TREATMENT RATIONALE & PLAN

Ms. Anderson presents with clinical and radiographic evidence of left L5 radiculopathy secondary to L4-L5 disc herniation with nerve root compression. Her symptoms have persisted for 14 weeks despite comprehensive conservative management. Physical examination demonstrates objective neurological deficits including motor weakness and dermatomal sensory changes. MRI imaging confirms anatomical correlation with disc herniation and nerve root impingement at the symptomatic level.

Based on the chronicity of symptoms, failure of conservative care to provide adequate relief, concordant imaging findings, and significant functional impairment, a fluoroscopy-guided lumbar interlaminar epidural steroid injection is recommended. The procedure aims to

reduce neural inflammation around the affected nerve root and provide symptomatic relief to allow more effective participation in ongoing physical therapy and functional restoration.

Proposed Treatment Approach:

- Fluoroscopy-guided lumbar interlaminar epidural steroid injection at L4-L5 level
- Contrast injection (Omnipaque 240, 1-2mL) to confirm epidural spread and exclude vascular uptake
- Therapeutic injection: Dexamethasone 10mg (non-particulate corticosteroid) mixed with 2mL Lidocaine 1%
- Real-time fluoroscopic guidance in anteroposterior and lateral views Post-
- procedure observation for 30 minutes

Concurrent and Post-Procedure Management Plan:

- Continue physical therapy 2x weekly focusing on core stabilization and gradual progression of functional activities
- Maintain current medication regimen (Gabapentin 900mg TID, Naproxen 500mg BID PRN)
- Continue daily home exercise program
- Ergonomic optimization of workstation (already in progress)
- Follow-up appointment 2 weeks post-procedure to assess treatment response
- Reassessment of symptoms and functional status at follow-up visit
- If inadequate response to single injection, will reassess treatment options at 3month mark

Expected Outcomes: Anticipated reduction in radicular pain and paresthesias, improvement in sleep quality, enhanced ability to participate in physical therapy, gradual return to normal work productivity and recreational activities.

Alternative Treatment Considerations: Surgical consultation for possible discectomy has been discussed with patient as an alternative if epidural injection does not provide adequate relief. Patient prefers to proceed with epidural steroid injection first given less invasive nature and wishes to avoid surgery if possible.

FACILITY INFORMATION

Procedure Location:	Midwestern Spine & Orthopedic Associates - Ambulatory Procedure Suite
Facility Address:	4200 Healthcare Drive, Suite 320, Minneapolis, MN 55404
Facility Phone:	(612) 555-8900
Facility NPI:	8473625910
Accreditation:	AAAHC Accredited Facility

Respectfully Submitted,

Rachel Kim, MD
Board Certified Physical Medicine & Rehabilitation
Midwestern Spine & Orthopedic Associates

Electronically Signed: July 16, 2024 at 3:22 PM CDT
Provider NPI: 7362849501

For questions regarding this authorization request, please contact:
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