CENTRAL SPINE INSTITUTE

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PRIOR AUTHORIZATION REQUEST

Epidural Steroid Injection Procedure

PATIENT DEMOGRAPHICS

Patient Name:	Margaret L. Foster
Date of Birth:	12/08/1956 (67 years old)
Member ID:	UHC-9384756
Referring Physician:	Sarah Johnson, MD (Primary Care)
Performing Physician:	Michael Rodriguez, MD - Pain Management
NPI:	9876543211
Request Date:	March 18, 2024

PROCEDURE INFORMATION

CPT Code:	62323 - Injection(s), of diagnostic or therapeutic substance(s), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal)
Procedure Details:	Fluoroscopy-guided lumbar interlaminar epidural steroid injection, L4-L5 level, with contrast confirmation
Steroid Agent:	Dexamethasone 10mg (non-particulate)
Proposed Date:	April 2, 2024

DIAGNOSIS

Primary Diagnosis: M48.06 - Spinal stenosis, lumbar region

Secondary Diagnosis: M54.5 - Low back pain
M54.17 - Neurogenic claudication

CLINICAL PRESENTATION

Chief Complaint: Bilateral leg pain with walking

History of Present Illness:
Mrs. Foster is a 67-year-old retired teacher who presents with 12-week history of progressive bilateral lower extremity pain and weakness with ambulation. She reports symptoms begin after walking approximately 2 blocks and include heaviness, cramping pain in bilateral thighs and calves, and occasional numbness in feet. Symptoms are relieved within 5-10 minutes of sitting or leaning forward (shopping cart sign positive). Denies pain at rest. Symptoms have progressively worsened over past 3 months, now limiting her ability to exercise, shop, or walk her dog.

Patient describes pain as dull, aching quality in bilateral lower extremities. Pain starts in buttocks and radiates down posterior thighs to calves. Rates pain as 7/10 on numeric rating scale when symptomatic. She reports feeling "like my legs won't work" after walking short distances. Symptoms completely resolve with forward flexion or sitting.

Impact on Function: Patient previously walked 2 miles daily for exercise but now cannot walk more than 2 blocks without severe symptoms. Uses shopping cart for support when grocery shopping. Has stopped attending mall walking group with friends due to symptoms.

CONSERVATIVE TREATMENT HISTORY

Treatment Modality	Duration	Response
NSAIDs (Meloxicam 15mg daily)	8 weeks	Minimal improvement in pain intensity
Gabapentin 300mg TID	6 weeks	Slight improvement in paresthesias, no change in walking tolerance
Physical Therapy	6 weeks (12 sessions)	Learned flexion-based exercises, <20% improvement in walking distance

Home Exercise Program	Ongoing (6 weeks)	Able to perform exercises but minimal impact on neurogenic claudication
Activity Modification	12 weeks	Uses shopping cart for support, frequent sitting breaks

Treatment Summary: Patient has completed 12 weeks of comprehensive conservative management including medications, physical therapy, and activity modification with less than 30% improvement in symptoms. Patient reports conservative treatment has not provided adequate relief to return to previous activity level.

PHYSICAL EXAMINATION

Examination Date: March 15, 2024

Vital Signs: BP 138/82, HR 74, BMI 27.8, Temp 98.4°F

Musculoskeletal Examination:

- Lumbar spine: Moderate limitation of extension (reproduces symptoms), flexion to fingertips to knees
- Tenderness to palpation bilateral paraspinal muscles L3-S1
- No spinal deformity or step-off
- Forward flexion relieves lower extremity symptoms (positive shopping cart sign)

Neurological Examination (At Rest):

- **Motor:** 5/5 strength bilateral lower extremities all muscle groups
- **Sensory:** Intact to light touch bilateral L2-S1 dermatomes
- **Reflexes:** Patellar 2+ bilateral, Achilles 1+ bilateral (symmetrically diminished)
- **Gait:** Normal at rest, narrow-based
- **Straight Leg Raise:** Negative bilaterally (no radicular symptoms)

Neurological Examination (Post-Ambulation):

After 5-minute walk test:

- Reproduced bilateral lower extremity pain and heaviness
- Bilateral quadriceps weakness 4/5 (compared to 5/5 at rest)
- Gait became more cautious and slower

- Symptoms resolved within 5 minutes of sitting

FUNCTIONAL ASSESSMENT

Numeric Rating Scale (NRS) for Leg Pain: 7/10 when symptomatic, 1/10 at rest

Oswestry Disability Index (ODI): 48% (Moderate to Severe Disability)
Administered: March 15, 2024

Domain	Score
Pain Intensity	3/5
Personal Care	1/5
Lifting	3/5
Walking	4/5
Sitting	1/5
Standing	4/5
Sleeping	2/5
Social Life	3/5
Traveling	4/5
Recreation	5/5

Walking Tolerance: Maximum walking distance 2 blocks before severe symptoms. Previously able to walk 2 miles.

DIAGNOSTIC IMAGING

MRI Lumbar Spine (without contrast)
Date: March 1, 2024
Facility: Arizona Imaging Center
Technique: Standard lumbar spine protocol including T1, T2, and STIR sequences in sagittal and axial planes.

Findings:

- **L3-L4:** Mild degenerative changes, no significant stenosis
- **L4-L5:** Severe central canal stenosis measuring 8mm AP diameter (normal >12mm). Moderate facet joint hypertrophy bilaterally. Ligamentum flavum thickening measuring 6mm. Grade 1 degenerative anterolisthesis. Moderate bilateral foraminal narrowing. No definite nerve root compression at foraminal levels.
- **L5-S1:** Mild diffuse disc bulge, mild central stenosis, patent foramina
- Vertebral body heights and alignment preserved except as noted
- No evidence of fracture or marrow signal abnormality
- Conus medullaris terminates at L1, normal appearance

Impression:

1. Severe central canal stenosis at L4-L5 with multilevel degenerative changes
2. Grade 1 degenerative anterolisthesis L4 on L5
3. Findings consistent with neurogenic claudication

ASSESSMENT & TREATMENT PLAN

Assessment:
67-year-old female with clinical and radiographic findings consistent with lumbar spinal stenosis at L4-L5 presenting with classic neurogenic claudication. Patient experiences position-dependent bilateral lower extremity symptoms that are relieved by forward flexion and sitting (shopping cart sign positive). MRI demonstrates severe central canal stenosis at L4-L5 concordant with clinical presentation. Symptoms have persisted for 12 weeks despite comprehensive conservative management including medications, physical therapy with flexion-based exercises, and activity modification.

Patient's symptoms significantly limit her functional capacity and quality of life, particularly her ability to ambulate for exercise and daily activities. ODI score of 48% confirms significant disability. Patient is motivated to avoid surgical intervention if possible and wishes to attempt epidural steroid injection as part of continued conservative management.

Treatment Plan:

1. Fluoroscopy-guided lumbar interlaminar epidural steroid injection at L4-L5 with contrast confirmation prior to injection of dexamethasone 10mg (non-particulate steroid)
2. Continue gabapentin 300mg TID for neuropathic symptoms
3. Continue home flexion-based exercise program daily

4. Continue physical therapy 2x per week focusing on core stabilization and flexion-based activities
5. Follow-up 2 weeks post-procedure to assess response using NRS and ODI
6. Anticipated outcome: Reduction in inflammation around thecal sac and nerve roots to improve walking tolerance and reduce pain
7. If <50% improvement at 3-month follow-up, will reassess treatment options including surgical referral

Procedure Details:
Procedure will be performed in our accredited ambulatory surgical center under fluoroscopic guidance. Patient will be positioned prone. After sterile prep and local anesthesia, epidural needle will be advanced to L4-L5 interlaminar space using fluoroscopic visualization. Contrast will be injected under live fluoroscopy to confirm epidural spread and absence of vascular uptake. Following confirmation of appropriate placement, dexamethasone 10mg mixed with preservative-free normal saline will be injected. Patient will be monitored for 30 minutes post-procedure.

Medical Necessity Statement:
This procedure is medically necessary for treatment of symptomatic lumbar spinal stenosis with neurogenic claudication that has failed comprehensive conservative management for 12 weeks. Patient has concordant clinical findings and MRI evidence of severe central canal stenosis at L4-L5. Epidural corticosteroid injection is indicated to reduce neural inflammation and improve ambulation tolerance, allowing continued conservative management and potentially avoiding surgical intervention.

Alternative Treatments Considered:

- Continued conservative management alone: Insufficient improvement after 12 weeks
- Surgical decompression: Patient wishes to exhaust conservative options before considering surgery
- Continued oral steroids: Increased systemic side effects, less targeted approach

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Electronically Signed: Michael Rodriguez, MD
Board Certified in Anesthesiology and Pain Medicine
Date/Time: March 18, 2024 at 10:47 AM MST

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