Service Order | Notes | Interaction History | Medical Review | Nurse Review | Member Information | Authorization Date Update | Cloned Details

Service Order ID:	Member:	Date of Birth:	Age:	Gender:	Member ID:	PRI-ME:
[redacted]	[redacted]	[redacted]	52	Male	[redacted]	

SO Status:	Medical Status:	Program:	Referring Physician:	Primary Specialty:	Case Specialty:
Open	Notes Received	Commercial CIGNA SI-PPO/OAP	CHAPLICK, MARK	ANESTHESIOLOGY	Interventional Pain

Medical Record Required

Nurse Job Aid | Clone Case

Header Information

Requested Study

Unit	CPT ID	Description	Modifier	Body Part	Description
1	64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	LT		
1	64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)	LT		
1	64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)	RT		
1	64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	RT		

*ICD-10 Code	ICD Description
M47.816	SPONDYLOSIS WITHOUT MYELOPATHY OR RADICULOPATHY, LUMBAR REGION

ICD Version ICD-10

ICD/Descr [ ] Search

UM Product COMP MSK

Study MULTIPLE STUDIES

	Product ID	Description	Product Category
1	300189	Intervent Pain-RFA	PAIN MGMT
2	300191	Intervent Pain-Facet Lumb	PAIN MGMT

CPT, ICD, Guideline

CPT Info | Member Rational Text

Dup	Service Group Name	*Unit	CPT	Description	*Status	Rationale	Repost	Provider Language	Member Language	Additional Rationales	Description	Modifier	BodyPart	Description
☐		1	64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	Pending		Repost			Additional Rationales		RT		
☐		1	64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)	Pending		Repost			Additional Rationales		RT		

Activity History

	Step	Activity	Status	Start		End		Assigned Group	
☐	10	Initiate Request	3 - Completed	08/29/2024	9:15AM	04/01/2024	9:15AM	Intake Workgroup	WEBUSER WEBUSER
☐	20	Give Verbal Recap, If Approved - Do Not Send To IVR	3 - Completed	08/29/2024	9:15AM	04/01/2024	9:15AM	Intake Workgrou	WEBUSER WEBUSE
☐	30	RN Review - Give Verbal Recap, If Approved - Do Not Send To IVR	2 - Started	08/29/2024	9:15AM			RN Workgroup	
☐	40	MD Review - Give Verbal Recap, If Approved - Do Not Send To IVR	1 - Queued					MD MSK Priority	
☐	50	NU Wrap Up - No Verbal Notification Required	1 - Queued					NU No Verbal Nc	
☐	60	Notify Member of Decision - SilverLink	1 - Queued					NU Member Noti	

Do Next Activity | Activity: | Step Number | Insert Activity | All Activities | Cancel Selected Activities | Cancel Service Order

Member History Information

Clinical Notes History | Claims Summary

150488863 **Initial Service Request:** ☐ **Date of Service:** 08/29/2024 **Place of Service:** Outpatient

Medical Status: Pending **Created:** **Member:** BERRY, JAMES W
SO Status: Open **Auth Start:** **Physician:** CHAPLICK, MARK B
Auth End: **Facility:** MIDWEST PAIN MANAGEMENT CENTER

Status	CPT		Rationale	
Pending	64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint		
Pending	64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)		

ICD Version	ICD ID	
10	M47.817	SPONDYLOSIS WITHOUT MYELOPATHY OR RADICULOPATHY, LUMBOSACRAL REGION

150424535 **Initial Service Request:** ☐ **Date of Service:** 08/29/2024 **Place of Service:** Outpatient

Medical Status: Modified Approved **Created:** 08/19/2024 **Member:** BERRY, JAMES W
SO Status: Complete **Auth Start:** 08/29/2024 **Physician:** CHAPLICK, MARK B
Auth ID: A71632865 **Auth End:** 02/25/2025 **Facility:** MIDWEST PAIN MANAGEMENT CENTER

Status	CPT		Rationale	
Denied	64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	M3014	
Denied	64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)	M3014	
Denied	64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)	M3014	
Approved	64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	44	Following consideration of the original adverse decision, the procedure has been approved based on review of the additional clinical information submitted.
Approved	64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	44	Following consideration of the original adverse decision, the procedure has been approved based on review of the additional clinical information submitted.
Approved	64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)	44	Following consideration of the original adverse decision, the procedure has been approved based on review of the additional clinical information submitted.
Approved	64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)	44	Following consideration of the original adverse decision, the procedure has been approved based on review of the additional clinical information submitted.

ICD Version	ICD ID	
10	M47.816	SPONDYLOSIS WITHOUT MYELOPATHY OR RADICULOPATHY, LUMBAR REGION

145578087 **Initial Service Request:**

Medical Status: Denied **Created:** 09/04/2023 **Member:** BERRY, JAMES W
SO Status: Complete **Auth Start:** 09/04/2023 **Physician:** MEHL, JAMIE S
Auth End: 03/02/2024 **Facility:** DIAGNOSTIC IMAGING CENTERS, PA

Status	CPT		Rationale	
Denied	74176	CT ABDOMEN and PELVIS; without contrast	96	
Approved	SOCCPT	SOCCPT	SOCAPP	Approved

ICD Version	ICD ID	
10	N20.0	CALCULUS OF KIDNEY

145563076 **Initial Service Request:**

Medical Status: Approved **Created:** 09/01/2023 **Member:** BERRY, JAMES W
SO Status: Complete **Auth Start:** 09/01/2023 **Physician:** MEHL, JAMIE S
Auth ID: A68339765 **Auth End:** 02/28/2024 **Facility:** DIAGNOSTIC IMAGING CENTERS, PA

Status	CPT		Rationale	
Approved	74176	CT ABDOMEN and PELVIS; without contrast	897	Approve
Approved	SOCCPT	SOCCPT	SOCAPP	Approved

ICD Version	ICD ID	
10	N20.0	CALCULUS OF KIDNEY

Clinical Advantage

View/Edit Survey | Call Tier2 PRI-ME/ Update Survey Status **Eligible** N **In Worklist:**
Survey:
P4/ PRI-ME Tier 1: Normal
PRI-SM/Survey Status:
PRI-ME Tier 2:
Notes

Clinical attachment added via Web Portal 08/22/2024 1:20PM webuser

Clinical note added via Web Portal 08/22/2024 1:20PM webuser
Request is for repeat bilateral Lumbar RFA L4-5 and L5-S1. Last RFA was 11/2022 and patient had 100% relief for 1/5 years.

UPADNotes 08/22/2024 1:20PM webuser
UPADNotes

Web Portal Attestation Note 08/22/2024 1:18PM webuser
The web user attested that this case was not urgent.

Current Medications

Taking

- Lisinopril-hydroCHLOROthiazide 10-12.5 MG Tablet TAKE 1 TABLET BY MOUTH EVERY DAY Oral
- Doxepin HCl 25 MG Capsule TAKE ONE CAPSULE BY MOUTH AT BEDTIME Oral
- Propranolol HCl 10 MG Tablet TAKE ONE TABLET BY MOUTH EVERY DAY Oral
- buPROPion HCl ER (XL) 150 MG Tablet Extended Release 24 Hour TAKE ONE TABLET BY MOUTH EVERY MORNING Oral
- Tadalafil 5 MG Tablet TAKE ONE TABLET BY MOUTH EVERY DAY AS DIRECTED Oral
- Albuterol Sulfate HFA 108 (90 Base) MCG/ACT Aerosol Solution INHALE ONE PUFF BY MOUTH EVERY 4 HOURS AS NEEDED (USE WITH SPACER) Inhalation
- tiZANidine HCl 4 MG Tablet TAKE ONE TABLET BY MOUTH THREE TIMES A DAY AS NEEDED Oral

Not-Taking

- Baclofen 10 MG Tablet TAKE 1 TO 2 TABLETS BY MOUTH THREE TIMES DAILY FOR 15 DAYS AS NEEDED FOR MUSCLE SPASM Oral
- Diclofenac Sodium 75 MG Tablet Delayed Release TAKE ONE TABLET BY MOUTH TWICE A DAY Oral

Medication List reviewed and reconciled with the patient

Past Medical History

- Bronchitis .
- Hypertension.

Surgical History

- Bilateral ACL
- Bilateral knee arthroscopies
- Right shoulder arthroscopy

Family History

- Non-Contributory

Social History

Tobacco Use:

- Tobacco Use/Smoking
  Are you a *nonsmoker*
  Additional Findings: Tobacco Non-User *Non-smoker for personal reasons*

PMA Social History:

- Social History
  Alcohol Use *Social Use*
  Tobacco User *Never Used*
  Recreational Drug User *Never Used*

Reason for Appointment

1. Reeval RF Lumbar Follow Up; RF Was 11/2022, 100% pain rekief for about 1.5 years.
2. Axial LBP is returning, he has had chronic LBP for years.
3. Now w difficulty getting comfortable to sleep
4. This is AXIAL LBP
5. No fracture, infection, tumor of the spine
6. Same pain as in 2022.
7. He has no radicular pain

History of Present Illness

Depression Screening:

- PHQ-2 (2015 Edition)
  Little interest or pleasure in doing things? *Not at all*
  Feeling down, depressed, or hopeless? *Not at all*
  Total Score *0*

Impact on Life:

- Activities of Daily Living
  Activities that are Greatly Impacted due to your pain. *bending,exercise,lifting objects,prolonged standing,walking*
- Activity and Lifestyle Modification
  Modifications Tried: *Change in Sleep Position,More Stretching,Taking More Breaks in the Day*
- Numeric Rating Scale (NRS): Pain Scores
  Pain at its Best: *2- Mild*
  Pain at its Worst: *9- Severe*
  Pain on Average (Last 7 days): *6- Distressing*
  Pain Right Now: *6- Distressing*

Clinical Indications:

- HX Conservative Care
  Pain: *Low Back*
  Previous Conservative Treatments Tried: *Home Exercise (Physician Directed),Hot/Cold Packs,Over the counter medications such as Aspirin, Tylenol, Ibuprofen, Naproxin,Anti-Inflammatories such as Voltaren, Mobic, Toradol,Muscle Relaxers such as Flexeril, Robaxin, Tizanidine, Soma, Baclofen*
  HEP: Month and Year you started Home Exercises *10/2022*
  HEP: Month and Year of last completing home exercise: *ongoing*
  HEP: Times per week of completing home exercise: *2-4*
  HEP: Who gave you the exercises: *Ortho/PCP*
  Hot/Cold Packs Effect: *Helped Pain for a short time*
  Over the counter Medication Effect: *Helped Pain for a short time*
  Over the Counters Tried: *Aleve, Tylenol, Ibuprofen*
  Muscle Relaxers Tried: *Tizanidine, Baclofen*
  Muscle Relaxers Effect: *Helped pain for a short time*
  Length of Conservative Treatments: *12 Weeks or more*

Medical Marijuana *No*

Functional Assessment low back:

- Revised Oswestry
  Section 1 - Pain Intensity *The pain is moderate at the moment. (2 points)*
  Section 2 - Personal Care (washing, dressing, etc.) *I can look after myself normally without causing extra pain. (0 point)*
  Section 3 - Walking *Pain does not prevent me from walking any distance. (0 point)*
  Section 4 - Lifting *Pain prevents me from lifting heavy weights, but I can manage light to medium weights. (3 points)*
  Section 5 - Sitting *Pain prevents me from sitting for more than 1 hour. (2 points)*
  Section 6 - Standing *Pain prevents me from standing for more than half an hour. (3 points)*
  Section 7 - Sleeping *Because of pain, I have less than 6 hours sleep. (2 points)*
  Section 9 - Social Life *My social life is normal and causes me no extra pain. (0 point)*
  Section 10 - Traveling *I can travel everywhere but it gives me extra pain. (1 point)*
  Total Raw Score: *13*
  Total % Score: *28.888888888888886*
  Interpretation: *Minimal disability*

Drugs/Alcohol:

- Alcohol Screen (Audit-C)
  Did you have a drink containing alcohol in the past year? *Yes*
  How often did you have a drink containing alcohol in the past year? *2 to 4 times a month (2 points)*
  How many drinks did you have on a typical day when you were drinking in the past year? *1 or 2 drinks (0 point)*
  How often did you have 6 or more drinks on one occasion in the past year? *Less than monthly (1 point)*
  Points *3*
  Interpretation *Negative*

Allergies

- N.K.D.A.

Hospitalization/Major Diagnostic Procedure

- see surgical history

Review of Systems

Neck:

- Stiffness denies.

Musculoskeletal:

- muscle or joint pain admits.
- back pain admits.
- swelling in joints denies.

Neurologic:

- headache denies.
- loss of strength admits.
- Loss of use of extremity denies.

- Imaging Date:
  Image Type *MRI Lumbar*
  Image Date: *12/21/2021*
- Active Rehabilitation/Current Conservative Treatment
  Active Rehabilitation/Physician Directed Conservative Treatments *Home Exercise provided to patient today,Rest/Ice/Heat*
- Procedure Results
  Procedure: *RF-Lumbar*
  Date of Procedure: *11/21/2022*

Functional Status:

- Outcome Assesment
  Standardized tool used for assessment: *Oswestry Disability Index (ODI)*

Pain Management:

- Pain Low Back.

Vital Signs

Wt: **185** lbs, Ht: **6 ft 2 in**, BMI: **23.75** Index, BP: **165/76** mm Hg, HR: **84** /min.

Assessments and Screeners

General Examination:

- GENERAL: in no acute distress, well developed, well nourished.
- CARDIOVASCULAR no murmurs, regular rate and rhythm, S1, S2 normal.
- RESPIRATORY clear to auscultation bilaterally.

Pain w lumbar ROM.

Assessments

1. Lumbar spondylosis - M47.816 (Primary)

Treatment and Plan

1. Lumbar spondylosis

PROCEDURE: RF-Lumbar (64635): Risk can include but not limited to Bruising at the site of injection, bleeding at the site of injection, tingling sensation or numbness

Notes: Bilateral Lumbar RFA L4-5 AND L5-S1 w 10mg po Valium. This procedure was reviewed by Brandy Alery on 08/08/2024 at 13:11 PM CDT

Follow Up

3 Weeks (Reason: Pt will call to schedule)

Electronically signed by Mark Chaplick , DO on 08/08/2024 at 10:31 AM CDT

Sign off status: Completed

Oswestry Low Back Pain Disability Index 2.1

Patient Name: [redacted] Date: [redacted] [redacted]

Primary care physician: Last seen:

Directions

This questionnaire has been designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life. Please answer every section.

Mark **one letter** only in each section that most closely describes you today.

Section 1 - Pain Intensity

- [ ] I have no pain at the moment. (0 point)
- [ ] The pain is very mild at the moment. (1 point)
- [x] The pain is moderate at the moment. (2 points)
- [ ] The pain is fairly severe at the moment. (3 points)
- [ ] The pain is very severe at the moment. (4 points)
- [ ] The pain is the worst imaginable at the moment. (5 points)

Section 2 - Personal Care (washing, dressing, etc.)

- [x] I can look after myself normally without causing extra pain. (0 point)
- [ ] I can look after myself normally but it is very painful. (1 point)
- [ ] It is painful to look after myself and I am slow and careful. (2 points)
- [ ] I need some help but manage most of my personal care. (3 points)
- [ ] I need help every day in most aspects of self-care. (4 points)
- [ ] I do not get dressed, wash with difficulty, and stay in bed. (5 points)

Section 3 - Walking

- [x] Pain does not prevent me from walking any distance. (0 point)
- [ ] Pain prevents me from walking more than one mile. (1 point)
- [ ] Pain prevents me from walking more than a quarter mile. (2 points)
- [ ] Pain prevents me from walking more than 100 yards. (3 points)
- [ ] I can only walk using a stick or crutches. (4 points)
- [ ] I am in bed most of the time and have to crawl to the toilet. (5 points)

Section 4 - Lifting

- [ ] I can lift heavy weights without extra pain. (0 point)

- [ ] I can lift heavy weights but it gives me extra pain. (1 point)
- [ ] Pain prevents me from lifting heavy weights off the floor. (2 points)
- [x] Pain prevents me from lifting heavy weights, but I can manage light to medium weights. (3 points)
- [ ] I can only lift very light weights. (4 points)
- [ ] I cannot lift or carry anything at all. (5 points)

Section 5 - Sitting

- [ ] I can sit in any chair as long as I like. (0 point)
- [ ] I can sit in my favorite chair as long as I like. (1 point)
- [x] Pain prevents me from sitting for more than 1 hour. (2 points)
- [ ] Pain prevents me from sitting for more than half an hour. (3 points)
- [ ] Pain prevents me from sitting for more than 10 minutes. (4 points)
- [ ] Pain prevents me from sitting at all. (5 points)

Section 6 - Standing

- [ ] I can stand as long as I want without extra pain. (0 point)
- [ ] I can stand as long as I want but it gives me extra pain. (1 point)
- [ ] Pain prevents me from standing for more than 1 hour. (2 points)
- [x] Pain prevents me from standing for more than half an hour. (3 points)
- [ ] Pain prevents me from standing for more than 10 minutes. (4 points)
- [ ] Pain prevents me from standing at all. (5 points)

Section 7 - Sleeping

- [ ] My sleep is never disturbed by pain. (0 point)
- [ ] My sleep is occasionally disturbed by pain. (1 point)
- [x] Because of pain, I have less than 6 hours sleep. (2 points)
- [ ] Because of pain, I have less than 4 hours sleep. (3 points)
- [ ] Because of pain, I have less than 2 hours sleep. (4 points)
- [ ] Pain prevents me from sleeping at all. (5 points)

Section 8 - Sex Life (if affected by pain)

- [ ] My sex life is normal and causes no extra pain. (0 point)
- [ ] My sex life is normal but causes some extra pain. (1 point)
- [ ] My sex life is nearly normal but is very painful. (2 points)
- [ ] My sex life is severely restricted by pain. (3 points)

- [ ] My sex life is nearly absent because of pain. (4 points)
- [ ] Pain prevents any sex life at all. (5 points)

Section 9 - Social Life

- [x] My social life is normal and causes me no extra pain. (0 point)
- [ ] My social life is normal but increases the degree of pain. (1 point)
- [ ] Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sports, etc. (2 points)
- [ ] Pain has restricted my social life and I do not go out as often. (3 points)
- [ ] Pain has restricted social life to my home. (4 points)
- [ ] I have no social life because of pain. (5 points)

Section 10 - Traveling

- [ ] I can travel everywhere without pain. (0 point)
- [x] I can travel everywhere but it gives me extra pain. (1 point)
- [ ] Pain is bad but I manage journeys over two hours. (2 points)
- [ ] Pain restricts me to journeys of less than one hour. (3 points)
- [ ] Pain restricts me to short necessary journeys under 30 minutes. (4 points)
- [ ] Pain prevents me from traveling except to receive treatment. (5 points)

Total Raw Score:

13

Total % Score:

28.888888888888886

Interpretation:

- [x] Minimal disability
- [ ] Moderate disability
- [ ] Severe disability
- [ ] Crippled
- [ ] Complete disability

Depression Screening PHQ2 (2015 Edition)

Name: [redacted]

Over the past 2 weeks, how often have you been bothered by any of the following problems:

Little interest or pleasure in doing things?

- [x] Not at all
- [ ] Several days
- [ ] More than half the days
- [ ] Nearly every day
- [ ] Declined to specify

Feeling down, depressed, or hopeless?

- [x] Not at all
- [ ] Several days
- [ ] More than half the days
- [ ] Nearly every day
- [ ] Declined to specify

Total Score 0

Interpretation

Score	*Probability of major depressive disorder (%)*	*Probability of any depressive disorder (%)*
1	15.4	36.9
2	21.1	48.3
3	38.4	75.0
4	45.5	81.2
5	56.4	84.6
6	78.6	92.9

Interpretation of Total Score

" 0=Declined to Specify

" 0=Not at all

" 1=Several days

" 2=More than half the days

" 3=Nearly every day

Reason for Appointment
1. RF Lumbar: M47.816
2. Superior response to MBB x2
3. No leg pain
4. No fusion
5. Pain is chronic
6. Unresponsive to conservative care.

Assessments and Screeners
General Examination:

CONSTITUTIONAL in no acute distress, well developed, well nourished.
CARDIOVASCULAR no murmurs, regular rate and rhythm, S1, S2 normal.
RESPIRATORY clear to auscultation bilaterally.

Assessments
1. Spondylosis - M47.9 (Primary)
2. Facet joint disease - M47.819
3. Pain aggravated by activities of daily living - R52

Procedures
*Lumbar Radiofrequency Ablation Under Fluoroscopy:

Level(s)/Side(s) Bilateral L4-L5, L5-S1,

.

Diagnosis M47.816: Spondylosis w/o Myelopathy Lumbar.
Type of Procedure Therapeutic.
Local Anesthetic Injected 3 mL Lidocaine 1%.
Sedation Medications IV Conscious Sedation VERSED 5mg and 50mcg Fentanyl.

.

Risks and Benefits Time out was taken to identify the correct patient, procedure and site prior to starting procedure. After a discussion of the procedure, including the benefits and risks, including but not limited to, infection, abscess, bleeding, hematoma, nerve damage, paralysis, pain, and soreness, informed consent was obtained.

Procedure Details The patient was taken to the procedure room and placed in the prone position. The area was prepared and draped in sterile fashion. The anesthetic stated above was injected in the skin and subcutaneous tissue. I then injected 3 mL Lidocaine 1% AP, oblique and lateral viewing using fluoroscopy confirmed appropriate positioning, a 100mm x 20g with active 10mm tip radiofrequency needles were inserted at the appropriate levels and sides stated above, of the spine above the transverse process just lateral to the pedicle. Sensory stimulation and motor stimulation were not performed. The Stryker Venom system was utilized. Lesioning commenced for 1 minute at 80 degree centigrade at all 6 nerves without complication.

Response to Procedure The procedure was completed without complications and was tolerated well. The patient was monitored after the procedure. The patient (or responsible party) was given post-procedure and discharge instructions to follow at home. The patient was discharged in stable condition. All orders on the Operative/Procedure Record were given verbally, read back to the physician and implemented.

Pre and Post Pain Scores Preop pain score 3-8. Post op score reduced..

Procedure Codes
64635 DESTROY L/S FACET JOINT NERVE SINGLE, Modifiers: 50
64636 DESTROY L/S FACET JOINT NERVE EA ADDTL, Modifiers: 50

Follow Up
prn

Electronically signed by Mark Chaplick on 11/21/2022 at 09:25 AM CST

Sign off status: Completed

Reason for Appointment
1. MNBB Lumbar: M47.817
2. This is MBB #2
3. That was the best his back has felt in 15 years.
4. Pain is chronic
5. No leg pain and no fusion
6. Unresponsive to conservative care.
7. No tumor, fracture or infection.

Assessments and Screeners
General Examination:

CONSTITUTIONAL in no acute distress, well developed, well nourished.
CARDIOVASCULAR no murmurs, regular rate and rhythm, S1, S2 normal.
RESPIRATORY clear to auscultation bilaterally.

Assessments
1. Spondylosis - M47.9 (Primary)
2. Facet joint disease - M47.819
3. Pain aggravated by activities of daily living - R52

Procedures
*Lumbar Medial Branch Block Under Fluoroscopy:

Level(s)/Side(s) Bilateral L4-L5, L5-S1,

.

Type of Injection diagnostic

.

Medications Injected 0.5 mL of Bupivacaine 0.25%.
Local Anesthetic Injected 20 mL Bupivacaine 0.25%.
Sedation Medication None.
Risks and Benefits Time out was taken to identify the correct patient, procedure and site prior to starting procedure. After a discussion of the procedure, including the benefits and risks, including but not limited to, infection, abscess, bleeding, hematoma, nerve damage, paralysis, dural puncture headache, pain, and soreness, informed consent was obtained..
Procedure Details The patient was taken to the procedure room and placed in the prone position. The area was prepared and draped in sterile fashion. The vertebral bodies were squared off at the corresponding levels. Local anesthetic wheals were raised with 20 mL Bupivacaine 0.25%. Under fluoroscopy a 22 gauge 3.5 inch needle was advanced at the above stated level/s and sides. Isovue M-200 was not required. I then injected 0.5 mL of Bupivacaine 0.25% at each level.
Response to procedure The procedure was completed without complications and was tolerated well. The patient was monitored after the procedure. The patient (or responsible party) was given post-procedure and discharge instructions to follow at home. The patient was discharged in stable condition. , The patient was instructed to keep a pain diary for the rest of the day and to call with the results to our clinic the next day. All orders on the Operative/Procedure Record were given verbally, read back to the physician and implemented.

Pre and Post Pre and Post procedure pain scores can be found in the ASC nursing note.

Procedure Codes
64493 FACET JOINT INJ L/S 1ST, Modifiers: KX
64494 FACET JOINT INJ L/S 2ND, Modifiers: 50

Follow Up
prn

Electronically signed by Mark Chaplick on 10/28/2022 at 02:28 PM CDT
Sign off status: Completed

Reason for Appointment
1. M47.816
2. Here for MBB #1
3. No leg pain
4. No fusion
5. Pain is chronic
6. Unresponsive to conservative care.
7. See H and P

Assessments and Screeners
General Examination:

CONSTITUTIONAL in no acute distress, well developed, well nourished.
CARDIOVASCULAR no murmurs, regular rate and rhythm, S1, S2 normal.
RESPIRATORY clear to auscultation bilaterally.

Assessments
1. Spondylosis - M47.9 (Primary)
2. Facet joint disease - M47.819
3. Pain aggravated by activities of daily living - R52

Procedures
*Lumbar Medial Branch Block Under Fluoroscopy:

Level(s)/Side(s) Bilateral L4-L5, L5-S1,
.
Diagnosis M47.816: Spondylosis W/O Myelopathy Lumbar.
Type of Injection diagnostic
.
Medications Injected 0.5 mL of Bupivacaine 0.25%.
Local Anesthetic Injected 20 mL Bupivacaine 0.25%.
Sedation Medication None.
Risks and Benefits Time out was taken to identify the correct patient, procedure and site prior to starting procedure. After a discussion of the procedure, including the benefits and risks, including but not limited to, infection, abscess, bleeding, hematoma, nerve damage, paralysis, dural puncture headache, pain, and soreness, informed consent was obtained..

Procedure Details The patient was taken to the procedure room and placed in the prone position. The area was prepared and draped in sterile fashion. The vertebral bodies were squared off at the corresponding levels. Local anesthetic wheals were raised with 20 mL Bupivacaine 0.25%. Under fluoroscopy a 22 gauge 3.5 inch needle was advanced at the above stated level/s and sides. Isovue M-200 was not required. I then injected 0.5 mL of Bupivacaine 0.25% at each level.

Response to procedure The procedure was completed without complications and was tolerated well. The patient was monitored after the procedure. The patient (or responsible party) was given post-procedure and discharge instructions to follow at home. The patient was discharged in stable condition. , The patient was instructed to keep a pain diary for the rest of the day and to call with the results to our clinic the next day. All orders on the Operative/Procedure Record were given verbally, read back to the physician and implemented.

Pre and Post Pre and Post procedure pain scores can be found in the ASC nursing note.

Procedure Codes
64493 FACET JOINT INJ L/S 1ST, Modifiers: 50
64494 FACET JOINT INJ L/S 2ND, Modifiers: 50

Follow Up
prn

Electronically signed by Mark Chaplick on 10/06/2022 at 04:21 PM CDT
Sign off status: Completed

Current Medications

Taking

- Lisinopril-hydroCHLOROthiazide 10-12.5 MG Tablet TAKE 1 TABLET BY MOUTH EVERY DAY Oral
- Baclofen 10 MG Tablet TAKE 1 TO 2 TABLETS BY MOUTH THREE TIMES DAILY FOR 15 DAYS AS NEEDED FOR MUSCLE SPASM Oral

Medication List reviewed and reconciled with the patient

Past Medical History

Bronchitis .
Hypertension.

Surgical History

Bilateral ACL
Bilateral knee arthroscopies
Right shoulder arthroscopy

Family History

Non-Contributory

Social History

Tobacco Use:
Tobacco Use/Smoking
Are you a *nonsmoker*
Additional Findings: Tobacco Non-User *Non-smoker for personal reasons*
PMA Social History:
Social History
Alcohol Use *Social Use*
Tobacco User *Never Used*
Recreational Drug User *Never Used*
Medical Marijuana *No*
Functional Assessment low back:
Revised Oswestry
Section 1 - Pain Intensity *The pain is moderate at the moment. (2 points)*
Section 2 - Personal Care (washing, dressing, etc.) *I can look after myself normally without causing extra pain. (0 point)*
Section 3 - Walking *Pain does not prevent me from walking any distance. (0 point)*
Section 4 - Lifting *Pain prevents me from lifting heavy weights, but I can manage light to medium weights. (3 points)*
Section 5 - Sitting *Pain prevents me from sitting for more than 1 hour. (2 points)*
Section 6 - Standing *Pain prevents me from standing for more than half an hour. (3 points)*
Section 7 - Sleeping *Because of pain, I have less than 6 hours sleep. (2 points)*
Section 8 - Sex Life (if affected by pain) *My sex life is normal and causes no extra pain. (0 point)*
Section 9 - Social Life *My social life is normal and causes me no extra pain. (0 point)*
Section 10 - Traveling *I can travel everywhere but it gives me extra pain. (1 point)*

Reason for Appointment

1. Lumbar pain
2. See Feb H and P
3. Options discussed
4. No fusion and no leg pain
5. Unresponsive to conservative care
6. He wants the RFA procedure we talked about in February.

History of Present Illness

PEG:
Pain Screening Tool (2018 Edition)
What number best describes your pain on average in the past week? *4*
What number best describes how, during the past week, pain has interfered with your enjoyment of life? *5*
What number best describes how, during the past week, pain has interfered with your general activity? *4*
Score: *4.33*
Assessment Form-New and Re-Eval:
Pain Scale
Pain Right Now: *3*
Pain at its Worst: *5*
Pain at its Best: *3*
Pain on average over the last month: *4*
Assessment Form-Established:
Pain Intake
Today's Pain: *Existing Pain (previously treated by us before)*
What is your chief pain complaint? *Lower back*
Since your last visit has your pain: *Stayed the same*
Aggravating Factors or Activities of Daily Living: *Continue*
Prolonged Sitting: *Increases Pain*
Sitting: *No Change in Pain*
Going up stairs: *Increases Pain*
Going down stairs: *No Change to Pain*
Walking: *No Change to Pain*
Prolonged Standing: *Increases Pain*
Standing: *Increases Pain*
Squatting: *No Change to Pain*
Kneeling: *No Change to Pain*
Lifting Objects: *Increases Pain*
Exercise: *No Change to Pain*
Straightening: *Decreases Pain*
Stretching: *Decreases Pain*
Bending: *Decreases Pain*
Activity and Lifestyle Modification: *Change in Sleep Position or Habits,Home Exercise,More Stretching,Taking more breaks in the day*
Result of taking more breaks in the day: *Decreased Pain for a short time*
Result of stretching more: *Decreased Pain for a short time*

Total Raw Score: *13*
Total % Score: *26*
Interpretation: *Minimal disability*
Drugs/Alcohol:
Alcohol Screen (Audit-C)
Did you have a drink containing alcohol in the past year? *Yes*
How often did you have 6 or more drinks on one occasion in the past year? *Less than monthly (1 point)*
How many drinks did you have on a typical day when you were drinking in the past year? *1 or 2 drinks (0 point)*
How often did you have a drink containing alcohol in the past year? *2 to 4 times a month (2 points)*

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
Denies Past Hospitalization

Review of Systems
Neck:
Stiffness denies.
Musculoskeletal:
muscle or joint pain admits. back pain admits. swelling in joints denies.
Neurologic:
headache denies. loss of strength admits. Loss of use of extremity denies.

Result of Home Exercise: *No change in Pain*
Result of Change in Sleep Position or Habits: *Decreased pain for a short time*

Vital Signs
Wt: 190 lbs, Ht-cm: 190.50 cm, Ht: 6 ft 3 in, BMI: 23.75 Index, BP: 136/81 mm Hg, Wt-kg: 86.18 kg, HR: 101 /min.

Physical Examination
GENERAL EXAM:
CONSTITUTIONAL well developed , well norished , in no acute distriess.
HEAD atraumatic , normocephalic.
EYES both eyes normal.
LYMPHATIC no lymphedema or distention.
SKIN no rashes , no suspicious lesions.
CARDIOVASCULAR regular rate and rhythm.
RESPIRATORY nonlabored , normal breath sounds.
GASTROINTESTINAL soft , non tender , nondistended.
PSYCHIRATRIC oriented , alert , cognitive function intact.
MUSCULOSKELETAL Pain on extension and sidebending L spine..

Assessments
1. Spondylosis - M47.9 (Primary)
2. Pain aggravated by activities of daily living - R52
3. Facet joint disease - M47.819

Treatment and Plan
1. Spondylosis
PROCEDURE: Medial Branch-Lumbar: Risk can include but not limited toPain at injection site, injection, bleeding, and nerve injury
Bilateral lumbar MBB L4-5 and L5-S1. This procedure was reviewed by Brandy Alery on 08/25/2022 at 10:14 AM CDT

Assessments and General Info
Billing:
Information
Activities associated with patient encounter: *documenting clinical information in the electronic or other health record*

Follow Up
3 Weeks

Electronically signed by Mark Chaplick on 08/25/2022 at 10:10 AM CDT
Sign off status: Completed

Oswestry Low Back Pain Disability Index 2.1

Patient Name: [redacted] Date: [redacted]
Primary care physician: Last seen:

Directions
This questionnaire has been designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life. Please answer every section. Mark **one letter** only in each section that most closely describes you today.

Section 1 - Pain Intensity

- [ ] I have no pain at the moment. (0 point)
- [ ] The pain is very mild at the moment. (1 point)
- [x] The pain is moderate at the moment. (2 points)
- [ ] The pain is fairly severe at the moment. (3 points)
- [ ] The pain is very severe at the moment. (4 points)
- [ ] The pain is the worst imaginable at the moment. (5 points)

Section 2 - Personal Care (washing, dressing, etc.)

- [x] I can look after myself normally without causing extra pain. (0 point)
- [ ] I can look after myself normally but it is very painful. (1 point)
- [ ] It is painful to look after myself and I am slow and careful. (2 points)
- [ ] I need some help but manage most of my personal care. (3 points)
- [ ] I need help every day in most aspects of self-care. (4 points)
- [ ] I do not get dressed, wash with difficulty, and stay in bed. (5 points)

Section 3 - Walking

- [x] Pain does not prevent me from walking any distance. (0 point)
- [ ] Pain prevents me from walking more than one mile. (1 point)
- [ ] Pain prevents me from walking more than a quarter mile. (2 points)
- [ ] Pain prevents me from walking more than 100 yards. (3 points)
- [ ] I can only walk using a stick or crutches. (4 points)
- [ ] I am in bed most of the time and have to crawl to the toilet. (5 points)

Section 4 - Lifting

- [ ] I can lift heavy weights without extra pain. (0 point)
- [ ] I can lift heavy weights but it gives me extra pain. (1 point)

- [ ] Pain prevents me from lifting heavy weights off the floor. (2 points)
- [x] Pain prevents me from lifting heavy weights, but I can manage light to medium weights. (3 points)
- [ ] I can only lift very light weights. (4 points)
- [ ] I cannot lift or carry anything at all. (5 points)

Section 5 - Sitting

- [ ] I can sit in any chair as long as I like. (0 point)
- [ ] I can sit in my favorite chair as long as I like. (1 point)
- [x] Pain prevents me from sitting for more than 1 hour. (2 points)
- [ ] Pain prevents me from sitting for more than half an hour. (3 points)
- [ ] Pain prevents me from sitting for more than 10 minutes. (4 points)
- [ ] Pain prevents me from sitting at all. (5 points)

Section 6 - Standing

- [ ] I can stand as long as I want without extra pain. (0 point)
- [ ] I can stand as long as I want but it gives me extra pain. (1 point)
- [ ] Pain prevents me from standing for more than 1 hour. (2 points)
- [x] Pain prevents me from standing for more than half an hour. (3 points)
- [ ] Pain prevents me from standing for more than 10 minutes. (4 points)
- [ ] Pain prevents me from standing at all. (5 points)

Section 7 - Sleeping

- [ ] My sleep is never disturbed by pain. (0 point)
- [ ] My sleep is occasionally disturbed by pain. (1 point)
- [x] Because of pain, I have less than 6 hours sleep. (2 points)
- [ ] Because of pain, I have less than 4 hours sleep. (3 points)
- [ ] Because of pain, I have less than 2 hours sleep. (4 points)
- [ ] Pain prevents me from sleeping at all. (5 points)

Section 8 - Sex Life (if affected by pain)

- [x] My sex life is normal and causes no extra pain. (0 point)
- [ ] My sex life is normal but causes some extra pain. (1 point)
- [ ] My sex life is nearly normal but is very painful. (2 points)
- [ ] My sex life is severely restricted by pain. (3 points)

- [ ] My sex life is nearly absent because of pain. (4 points)
- [ ] Pain prevents any sex life at all. (5 points)

Section 9 - Social Life

- [x] My social life is normal and causes me no extra pain. (0 point)
- [ ] My social life is normal but increases the degree of pain. (1 point)
- [ ] Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sports, etc. (2 points)
- [ ] Pain has restricted my social life and I do not go out as often. (3 points)
- [ ] Pain has restricted social life to my home. (4 points)
- [ ] I have no social life because of pain. (5 points)

Section 10 - Traveling

- [ ] I can travel everywhere without pain. (0 point)
- [x] I can travel everywhere but it gives me extra pain. (1 point)
- [ ] Pain is bad but I manage journeys over two hours. (2 points)
- [ ] Pain restricts me to journeys of less than one hour. (3 points)
- [ ] Pain restricts me to short necessary journeys under 30 minutes. (4 points)
- [ ] Pain prevents me from traveling except to receive treatment. (5 points)

Total Raw Score:

<="" li="">13

Total % Score:

<="" li="">26

Interpretation:

- [x] Minimal disability
- [ ] Moderate disability
- [ ] Severe disability
- [ ] Crippled
- [ ] Complete disability

REFERRAL

STEPHANIE DE VERE, MD
Orthopedic Surgery

[redacted]

02/23/1972

Reason For Referral:

Authorization No:	**Authorization Type:**
Reason:	Evaluate and treat for possible lumbar injections including RFA, epidural, and facet injections , Please call patient to schedule and fax results to 816-525-2841.
Diagnosis:	M47.816 - Facet arthritis of lumbar region
E/M Codes:	
Procedures:	
Visits Allowed:	0
Unit Type:	V (VISIT)
Start Date:	01/24/2022
End Date:	01/24/2023

Current Medications
Taking
- Ibuprofen

Not-Taking
- Ativan 2 MG Tablet 1 tablet 60 minutes prior to procedure Orally Once a day
- HYDROcodone-Acetaminophen 5-325 MG Tablet 1 tablet as needed Orally every 6 hrs
- HYDROcodone-Acetaminophen

Medication List reviewed and reconciled with the patient

Past Medical History
Past Medical History:: bronchitis,back pain,pneumonia.

Surgical History
left knee arthroscopy 06/1999
right knee arthroscopy 7/2000
left knee ACL 12/1/16
right knee ACL recon 11/8/18
Left shoulder nanoscope arthroscopy biceps tenodesis and superior labral debridement 7-23-21

Family History
Non-Contributory

Social History
Tobacco Use:
Tobacco Use/Smoking
Are you a *former smoker*
How long has it been since you last smoked? *5-10 years*

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
Denies Past Hospitalization

Review of Systems
General/Constitutional:
Poor balance No. Fevers No.
Gastrointestinal:

Reason for Appointment
1. MRI Lumbar @ Element

History of Present Illness
Lumbar Spine/Lower Back:

This patient is here today regarding continued low back pain. He has previous x-rays in the SANO PACS system. He is here today to review his recent lumbar spine MRI completed at Element.

.

The patient reports his symptoms have remained relatively unchanged since his last visit.

The pain is located at the center of his low back and will occasionally radiate into the buttock region on both sides.

He also notices occasional numbness/tingling into the buttock region. He denies numbness/tingling in his legs.

He rates his pain as a 5/10 and describes it as an intense dull pain. His pain is aggravated by lifting in front of him and relieved by changing positions, activity modification. He does not have pain when he is lifting to the side of his body.

He denies leg heaviness.

He admits buttock pain.

He does not find improvement in leaning forward.

Past treatments for this condition include pain management and physical therapy which provided moderate improvement.

.

On further review of symptoms, he denies urinary or fecal incontinence, urinary retention or hesitancy, saddle anesthesia, difficulty with gait/balance, or clumsiness of the hands.

Vital Signs
Ht 74 in, Wt **205 lbs**, BMI **26.32 Index**, Ht-cm 187.96 cm, Wt-kg 92.99 kg.

Examination
General Examination:

CERVICAL SPINE EXAM

Inspection/Skin: Inspection of the spine and skin does not reveal any scars, abnormality, or gross deformity.

Gait: Gait exam reveals normal gait including tip toe, tandem,

Difficulty swallowing No.

Genitourinary:

Recent weight change No.

Musculoskeletal:

Extremity numbness/tingling No. Joint pain Yes. Loss of joint motion No. Locking/catching sensation Yes. Extremity weakness Yes. Groin numbness/tingling No.

Neurologic:

Paralysis or tremors No.

Relevant records were reviewed in preparation for the visit (ROS, PSFH, and available EMR charts), and relevant findings were incorporated into the history of present illness.

[illegible] and heel.

Coordination and Balance: Normal coordination with grasp release.

Vertebral spine tenderness: Absent

Trapezius tenderness: Absent bilaterally

Neck Range of Motion: Normal in all directions

.

Sensory and Motor Exam:

Motor:

C5 Elbow Flexion: 5 (right) and 5 (left)

C6 Wrist Extension: 5 (right) and 5 (left)

C7 Elbow Extension: 5 (right) and 5 (left)

C8 Finger Flexion: 5 (right) and 5 (left)

T1 Finger Abduction: 5 (right) and 5 (left)

Sensory:

C5: 2 (right) and 2 (left)

C6: 2 (right) and 2 (left)

C7: 2 (right) and 2 (left)

C8: 2 (right) and 2 (left)

T1: 2 (right) and 2 (left)

.

Reflexes:

DTR Biceps: 2+ (right) and 2+ (left)

DTR Triceps: 2+ (right) and 2+ (left)

DTR Bracho-Radialis: 2+ (right) and 2+ (left)

Hoffman: Negative (right) and negative (left)

.

LUMBAR SPINE EXAM

Inspection/Skin: Inspection of the spine and skin does not reveal any scars, abnormality or gross deformity.

Lower back palpation: No midline vertebral spine or paraspinal tenderness.

Stability: No overt evidence of curvature on exam.

.

Lower extremity sensory and motor exam:

LE (Motor)

L2 Hip Flexion: 5 (right) and 5 (left)

L3 Knee Extension: 5 (right) and 5 (left)

L4 Tib. Ant.: 5 (right) and 5 (left)

L5 EHL: 5 (right) and 5 (left)

S1 Gastroc: 5 (right) and 5 (left)

Bilateral Saddle: Rectal tone: Not assessed. Perianal sensation: Not assessed.

LE (Sensory)

L2: 2 (right) and 2 (left)

L3: 2 (right) and 2 (left)

L4: 2 (right) and 2 (left)

L5: 2 (right) and 2 (left)

S1: 2 (right) and 2 (left)

.

DTR's and pathologic reflexes:

DTR Patellar: 2+ (right) and 2+ (left)
DRT Achilles: 2+ (right) and 2+ (left)
Straight Leg Raise: Negative (right) and negative (left)
Clonus: 0 beats (right) and 0 beats (left)
Babinski: Downgoing (right) and downgoing (left).

Assessments

1. DDD (degenerative disc disease), lumbar - M51.36 (Primary)
2. Facet arthritis of lumbar region - M47.816
3. Foraminal stenosis of lumbar region - M48.061

Treatment

1. Facet arthritis of lumbar region

Clinical Notes:
MRI of the lumbar spine without contrast from 12/21/2021 at Element was reviewed by me. The images were compared to his previous MRI. The images demonstrate increased stenosis at L4-L5 due to epidural lipomatosis and ligamentum flavum thickening. Otherwise, the normal progression of degenerative changes.

This patient has lumbar facet arthritis based on a detailed review of his history, physical exam, and imaging. I have reviewed with him the natural history of facet OA and low back pain.

He has been referred to a pain management specialist, Dr. Mark Chaplick, for strategies for ongoing management. These should include daily exercise, cognitive behavioral therapy, stress management, non-opiate medications, and sleep hygiene. He could also consider a radiofrequency ablation to help minimize their pain.

We also discussed that OTC NSAIDs as needed are helpful for pain management. He should check with their PCP for verification that these medications are safe to take given their adverse effect profile.

I have advised him that at this point there is no need for advanced imaging and will follow up with him on an as-needed basis.

I have reviewed the signs and symptoms that should prompt him to seek urgent medical care. These include the development of saddle anesthesia, urinary retention, fecal incontinence, clumsiness, progressive weakness, or sensory changes.

Any questions were answered. The patient demonstrated understanding and is agreeable with the recommendations as discussed.

This note was generated for Stephanie de Vere, MD using the Robin service.

Referral To:Mark Chaplick Pain Medicine

Reason:Evaluate and treat for possible lumbar injections including RFA, epidural, and facet injections | Please call patient to schedule and fax results to 816-525-2841.

Medical History

Problem List

Onset Date	Code	Name	Specify	Notes	Added On	Modified On	Modified By
	Z09	Follow-up surgery care			11/26/2018	11/26/2018	BATCHELDER, JENNIFER C
		W/U Status: confirmed					
	M51.36	DDD (degenerative disc disease), lumbar			12/09/2021	01/24/2022	Brick, Jordin
		W/U Status: confirmed					
	M47.816	Facet arthritis of lumbar region			12/09/2021	01/24/2022	Brick, Jordin
		W/U Status: confirmed					

Past Medical History

Past Medical History:: bronchitis,back pain,pneumonia

Medications

Name strength formulation, Sig: take route frequency

Not-Taking HYDROcodone-Acetaminophen , Sig:

Not-Taking HYDROcodone-Acetaminophen 5-325 MG Tablet, Sig: 1 tablet as needed Orally every 6 hrs Start Date: 08/11/2021

Not-Taking Ativan 2 MG Tablet, Sig: 1 tablet 60 minutes prior to procedure Orally Once a day Start Date: 12/16/2021

Taking Ibuprofen , Sig:

Surgical History

Date	Reason
06/1999	left knee arthroscopy
7/2000	right knee arthroscopy
12/1/16	left knee ACL
11/8/18	right knee ACL recon
7-23-21	Left shoulder nanoscope arthroscopy biceps tenodesis and superior labral debridement

Hospitalization

Date	Reason

Name	Value
Drugs/Alcohol:	Drug history: Have you used drugs other than those for medical reasons in the past 12 months? No
Tobacco Use/Smoking	Tobacco history: Are you a former smoker, How long has it been since you last smoked? 5-10 years

Family History

Relation : Description

No Family History documented.

Vitals

Name	Date	Value
Ht	01/24/2022	74
Wt	01/24/2022	205
BMI	01/24/2022	26.32
Ht-cm	01/24/2022	187.96
Wt-kg	01/24/2022	92.99

Referrals

Incoming Referrals

Referral From	Referral To	Start Date	End Date	Reason
Michael Duke	MATTHEW C DAGGETT	11/01/2016	11/01/2017	left knee pain

Outgoing Referrals

Referral From	Referral To	Start Date	End Date	Reason
STEPHANIE L DE VERE	Mark Chaplick	01/24/2022	01/24/2023	Evaluate and treat for possible lumbar injections including RFA, epidural, and facet injections | Please call patient to schedule and fax results to 816-525-2841.
STEPHANIE L DE VERE	Element Medical Imaging	12/09/2021	12/09/2022	MRI of the lumbar spine without contrast | Please call patient to schedule and fax results to 816-525-2841.
MATTHEW C DAGGETT	Lee's Summit North EXOS	07/23/2021	07/23/2022	Evaluate & Treat. AROM. PROM. Progressive Exercises. Modalities PRN. 3x/wk 4 wks. HEP instruction. | Please send physical copy of plan of care with patient to their follow-up appointment with the provider. | s/p right shoulder nano arthroscopy with biceps tenodesis and superior labral debridement on 7/23/21 | sling x 2 weeks, start JPL p/o day 3, start PT 2 weeks p/o
MATTHEW C DAGGETT	Surg Sx PODS Lee's Summit Medical Center	07/23/2021	06/23/2022	Left shoulder nano arthroscopy with biceps tenodesis and superior labral debridement | 45 min, arthrex, smith and nephew, nano
MATTHEW C DAGGETT	Element Medical Imaging	05/25/2021	05/25/2022	Right Shoulder MRI Arthrogram with Contrast | Please call patient to schedule and fax results to 816-525-2841.
MATTHEW C DAGGETT	Element Medical Imaging	05/25/2021	05/25/2022	Left Shoulder MRI Arthrogram with Contrast | Please call patient to schedule and fax results to 816-525-2841.
MATTHEW C DAGGETT		10/26/2018	10/26/2019	Eval/Treat S/P Rt ACL Reconstruction 2-3x/wk for 6wks|AROM, PROM, Modalities, Manual Therapy, Progressive Exercises, HEP
MATTHEW C DAGGETT		11/08/2018	07/05/2019	Right knee Arthroscopy with ACL reconstruction (hamstring autograft), medial menisectomy|Arthrex; 90mins|Pre-op Britt
MATTHEW C DAGGETT	Scheduling Lee's Summit Medical Center	05/15/2018	05/15/2019	MRI Right Knee without Contrast

MATTHEW C DAGGETT	11/29/2016	11/29/2016	Lee's Summit Medical Center
MATTHEW C DAGGETT	11/29/2016	11/29/2016	Evaluate & Treat Left Knee S/P Lt Knee ACL Recon. 3x/wk for 4 weeks. AROM. PROM. Modalities PRN.
MATTHEW C DAGGETT	11/16/2016	11/16/2016	

MRI LUMBAR SPINE WITHOUT CONTRAST

Clinical History:

Chronic lower back pain.

Technique:

Multiple sequential multiplanar MRI images of the lumbar spine were obtained without contrast.

FINDINGS:

Transitional anatomy is present. This report assumes that there is an S1-S2 rudimentary disc. Mild retrolisthesis at L5-S1 is present. Otherwise curvature and alignment are normal. Vertebral body heights and disc spaces are normal. L4-L5 and L5-S1 disc desiccation is present, including L5-S1 posterior annular fissure. There is posterior epidural lipomatosis. The conus medullaris terminates at the upper L1 level with an unremarkable appearance.

At T12-L1, L1-L2, L2-L3, L3-L4, no significant disc disease, central canal or neural foraminal stenosis is present. L3-L4 mild facet arthropathy is present bilaterally.

At L4-L5, mild generalized disc bulging and ligamentum flavum thickening with posterior epidural lipomatosis is present. The combined findings contribute to mild central canal stenosis. Moderate facet arthropathy is present with mild-to-moderate right and mild left neural foraminal stenosis near the exiting L5 nerve roots.

At L5-S1, mild generalized disc bulging with small posterior annular fissure centrally is noted. There is no focal disc herniation. Mild ligamentum flavum thickening and epidural lipomatosis contributes to mild central canal stenosis. Moderate facet arthropathy is present with mild to moderate right and very mild left neural foraminal stenosis.

IMPRESSION:

1. L4-L5 and L5-S1 mild central canal stenosis due to mild generalized disc bulges, epidural lipomatosis and ligamentum flavum thickening. No focal herniations. Small L5-S1 posterior annular fissure.

2. Lower lumbar facet arthropathy. Mild-to-moderate right L4-L5 and right L5-S1 neural foraminal stenosis. Mild left L4-L5 and left L5-S1 neural foraminal stenosis.

Electronically Signed By: Jeremy Jagoda, MD, Signed On: 12/21/2021 4:16 PMDESKTOP-MGRHV8B