MARVIX AI

SAMPLE INTERVENTIONAL PAIN MEDICINE SOAP NOTE

POST-ABLATION REVIEW WITH NEW L5 RADICULOPATHY

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1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME
Rosalind M. Okafor-Byrne

DOB
04/23/1965

AGE / SEX
61 yrs / Female

MRN / PATIENT ID
IPM-33027

DATE OF SERVICE
08/05/2026

PROVIDER
Marcus Delacroix, MD

CREDENTIALS
MD, DABA, DABPM

REFERRAL SOURCE
Self-referred back to clinic; original referral orthopedics 09/2024

VISIT TYPE
Procedure Follow-Up — 6 weeks after bilateral L3–S1 radiofrequency ablation, with medication management

CARE SETTING
Outpatient interventional pain clinic

PRIMARY CARE PROVIDER
Kestrel Health Center — Dr. P. Anand

REFERRING SPECIALIST
Orthopedic spine — Dr. J. Lindqvist (discharged 03/2025)

CC CHIEF COMPLAINT

2 PRIMARY PAIN CONCERN

"The injections took the deep ache out of my back — that part worked. But my right leg is burning now in a way it never did before, and I'm frightened about coming off the oxycodone." — patient, at 6 weeks after bilateral lumbar medial branch radiofrequency ablation.

S SUBJECTIVE

3 PAIN HISTORY, PRIOR TREATMENT & FUNCTIONAL IMPACT

3a REASON FOR EVALUATION & PAIN CHARACTERIZATION

Reason for Interventional Pain Medicine Evaluation

Planned 6-week review of response to bilateral L3–S1 medial branch radiofrequency ablation performed 06/24/2026, combined with a scheduled opioid taper review. A **new complaint has emerged since the procedure** — right-sided burning leg pain in a distribution that was not present before — which changes the agenda of this visit.

Pain Location and Distribution

Axial low back pain, bilateral, paraspinal, L3 to S1, previously the dominant complaint — **substantially improved. New: right posterolateral thigh and calf burning** extending to the dorsum of the foot and the great toe, present for 4 weeks, continuous rather than intermittent, and clearly dermatomal in an L5 distribution. Left leg unaffected. No groin or perineal symptoms.

Pain Onset and Course

Axial back pain since a lifting injury at work in 03/2022 (she was a school caretaker), progressive over 4 years with no single deterioration event. **The new right leg burning began approximately 2 weeks after the ablation** and has been steadily worsening since, from 3/10 to 7/10. The temporal relationship to the procedure was raised by the patient herself and is addressed below.

Pain Character and Severity

Axial back: previously a deep constant ache, 7–8/10 at worst, now 2–3/10 with a best of 1 — **approximately 70% relief, sustained for 6 weeks. Right leg:** burning, electric, with intermittent shooting into the foot; 5/10 average, 7/10 worst, 3/10 best. Numbness over the dorsum of the right foot. Average combined pain has fallen from 7.5 to 4.5, but the character has changed from nociceptive to neuropathic.

Aggravating and Alleviating Factors

Back pain formerly worsened by extension, prolonged standing, and rotation and eased by sitting — a facet pattern that predicted her ablation response well. The **new leg pain is worse on walking more than 200 metres and on standing, and eases within 2–3 minutes of sitting or leaning forward over a trolley** — a flexion-relieved, walking-provoked pattern. Worse in the evening and disturbs sleep. Gabapentin has not helped at the current dose.

Associated Neurologic Symptoms

Numbness over the right dorsal foot and great toe. **New subjective weakness — she reports catching her right toe on carpet edges twice in the past fortnight and has tripped once.** No falls with injury. No left leg symptoms. **No bowel or bladder dysfunction, no saddle numbness, no urinary retention or incontinence** — specifically and repeatedly asked. No progressive bilateral weakness.

Functional Impact

Walking tolerance has fallen from 800 metres before the procedure to 200 metres now, entirely due to the leg. Conversely, she can now **stand at the kitchen counter to prepare a meal, sleep on her back, and get out of a car without help** — none of which she could do in May, and all attributable to the back improvement. Retired on health grounds 01/2025. Drives short distances only. Sleep disturbed 3–4 nights weekly by leg pain, having previously been disturbed nightly by back pain.

3b PRIOR TREATMENT, MEDICATIONS & SAFETY HISTORY

Prior Conservative Treatment

Eighteen sessions of physiotherapy across three episodes 2022–2025 with a graded exposure and core programme; partial short-term benefit. Independent home exercise programme, adherent 4–5 days weekly — genuinely so, verified by her exercise log. Twelve sessions of chiropractic care in 2023 with no lasting change. Acupuncture, 8 sessions, no benefit. Weight reduction of 9 kg since 2024, sustained. Pain psychology, 6 sessions in 2025, which she found valuable for pacing and catastrophising.

Prior Interventional Treatment

Diagnostic medial branch blocks: bilateral L3–S1, 02/18/2026 — 85% relief for 5 hours; repeat with a different local anaesthetic 03/24/2026 — 80% relief for 9 hours. Two concordant positive blocks. **Radiofrequency ablation:** bilateral L3, L4, L5 medial branches and L5 dorsal ramus, 06/24/2026, under fluoroscopic guidance, 80°C for 90 seconds per lesion, no sedation beyond local anaesthetic, uneventful. **Right L4–L5 transforaminal epidural steroid injection 11/2024** — 50% relief of leg pain for 6 weeks at a time when she had milder right leg symptoms. No prior facet intra-articular injection, no sacroiliac injection, no ablation revision, no neuromodulation.

Medication History and Response

Oxycodone modified release 10 mg twice daily plus 5 mg immediate release up to twice daily as needed — total 20–30 mg/day, approximately 30–45 morphine milligram equivalents. On opioids since 2023. **Taper agreed at the 06/24 visit and begun 07/01: reduced from 40 mg/day, currently at 20–30 mg/day — a 25–30% reduction achieved in 5 weeks with no withdrawal symptoms and no increase in her back pain.** Gabapentin 300 mg three times daily since 05/2026 — minimal benefit and she reports daytime drowsiness. Naproxen 500 mg twice daily as needed, roughly 3 days weekly. Paracetamol 1 g up to four times daily, taken regularly. Topical diclofenac. Duloxetine trialled 2024 and stopped for nausea. Amitriptyline trialled 2023 and stopped for dry mouth and morning sedation.

Opioid / Controlled Substance History

On opioids 3 years, peak dose 60 mg/day oxycodone equivalent in 2024. **PDMP reviewed today: single prescriber, single pharmacy, no early refills, no overlapping benzodiazepine or other sedative prescriptions.** Opioid treatment agreement signed 01/2024 and reviewed today. **Urine drug screen 08/05/2026: consistent — oxycodone and oxymorphone present, no non-prescribed substances.** Pill count today matched the dispensing record. **Naloxone dispensed and the patient and her husband trained 06/2026.** No aberrant behaviour at any point. She is anxious about the taper rather than resistant to it, which is an important distinction and shapes the plan. No alcohol, no tobacco for 11 years, no illicit substance use. Safe storage in a locked box confirmed — two grandchildren visit weekly.

Surgical / Spine History

No prior spine surgery. Right total knee arthroplasty 2019, good outcome. Abdominal hysterectomy 2011. No hardware, no fusion, no implanted pain device. Never previously offered spine surgery.

Relevant Medical History

Type 2 diabetes on metformin and semaglutide, HbA1c 7.1% — relevant both to steroid injection planning and to the differential for her burning leg pain. Hypertension on amlodipine. Hypercholesterolaemia on atorvastatin. Obesity, BMI 31.4 and falling. **No anticoagulant or antiplatelet therapy.** No immunosuppression, no active infection, no cancer history, no osteoporosis (DEXA 2025 T-score −0.9). Postmenopausal. Mild anxiety, unmedicated. No prior serious infection after any injection.

Recent Imaging / Testing

Lumbar MRI 01/2026 reviewed personally: multilevel facet arthropathy most marked at L4–L5 and L5–S1, **a right foraminal disc protrusion at L4–L5 contacting the exiting L4 root and mild-to-moderate right L5–S1 foraminal narrowing**, degenerative disc disease at three levels, grade 1 degenerative spondylolisthesis at L4–L5 with no instability on the standing films, and no central canal stenosis of significance. No EMG or nerve conduction study has ever been performed. Fluoroscopy report from 06/24 confirms accurate lesion placement.

Pertinent Negatives

No fever, chills, night sweats, or unexplained weight loss. No cancer history. No IV drug use, no immunosuppression. **No bowel or bladder dysfunction, no saddle anaesthesia, no bilateral leg symptoms.** No acute trauma. No injection-site infection, and no procedural complication reported at any point. No rapidly progressive weakness — the toe catching is subtle and has evolved over a fortnight, not hours.

ROS PAIN MEDICINE REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Pain distribution	**Positive — new right L5 radicular burning pain. Axial back pain much improved. Negative for left leg, neck, or upper limb pain**
Neurologic	**Positive — right dorsal foot numbness, subjective toe catching, one trip. Negative for falls with injury, balance disorder, bilateral weakness**

Red flags	**Negative — no bowel or bladder dysfunction, no saddle anaesthesia, no fever or chills, no unexplained weight loss**
Mood / sleep	**Positive — sleep disturbed 3–4 nights weekly by leg pain; taper-related anxiety. Negative for depression, PHQ-9 6, GAD-7 9**
Medication effects	**Positive — gabapentin-related daytime drowsiness, opioid-related constipation managed on laxatives. Negative for sedation from opioid, nausea, cognitive impairment**
Bleeding / infection risk	**Negative — no anticoagulant or antiplatelet therapy, no immunosuppression, no active infection. Diabetes with HbA1c 7.1% noted for steroid planning**
Function	**Positive — walking tolerance fallen 800 to 200 m from the leg; standing, sleeping, and car transfers all improved from the back**

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE	BLOOD PRESSURE
36.6°C	**132/78 mmHg**
HEART RATE	RESPIRATORY RATE
74 bpm	**16 / min**
OXYGEN SATURATION	HEIGHT
97% room air	**163 cm**
WEIGHT	BMI
83.4 kg (92.4 kg in 2024)	**31.4 kg/m² — down from 34.8**

PAIN SCORE

Back 2/10; right leg 5/10; combined average 4.5/10 (7.5 pre-procedure)

5a FOCUSED MUSCULOSKELETAL & NEUROLOGIC EXAMINATION

General Appearance

Comfortable seated, no distress at rest. Rises from the chair **without using her arms — a change from the pre-procedure visit**, when she needed to push up. No assistive device. Obese but noticeably slimmer than in May. Engaged, articulate, and accurate about her own timeline.

Inspection / Posture

Mild loss of lumbar lordosis with a slightly flexed standing posture **which she now adopts to relieve the leg**, whereas in May she stood extended and guarded. No scoliosis. No pelvic obliquity. No paraspinal atrophy. **Two well-healed radiofrequency needle entry sites at each of L3, L4, and L5 bilaterally — no erythema, swelling, tenderness, or discharge.**

Gait

Antalgic on the right with a shortened stance phase. **Subtle right foot slap on the initial contact phase and reduced toe clearance on the right**, corroborating the reported toe catching. Heel walking impaired on the right, intact on the left. Toe walking intact bilaterally. Tandem gait completed with mild unsteadiness. No Trendelenburg.

Range of Motion

Lumbar flexion 70° and comfortable. **Extension now 25° and pain-free** — in May extension was 10° and reproduced her dominant pain, and this change alone is objective evidence of ablation success. Rotation and lateral flexion full and painless bilaterally. Hip range of motion full and painless with negative FABER and FADIR.

Palpation

No facet-loading tenderness at L3–S1 bilaterally — previously marked and reproducible. No midline tenderness, no step-off. Mild right gluteal and sciatic notch tenderness, new. No sacroiliac tenderness on provocation. No trigger points. No allodynia over the ablation sites.

Motor Examination

Right extensor hallucis longus 4/5 and right tibialis anterior 4+/5 — both were 5/5 documented on 06/24/2026. Right extensor digitorum longus 4+/5. Right hip flexion, knee extension, plantarflexion, and eversion all 5/5. Left lower limb 5/5 throughout. No atrophy measurable; calf circumference equal at 37 cm bilaterally.

Sensory Examination

Reduced pinprick and light touch over the right L5 dermatome — dorsal foot, first web space, and great toe — estimated at 70% of the left side. Sensation intact in L4, S1, and S2 distributions and on the left throughout. **Perineal and perianal sensation intact.** No allodynia, no hyperalgesia.

Reflexes

Knee jerks 2+ and symmetrical. Ankle jerks 2+ and symmetrical — consistent with an L5 rather than S1 lesion. No clonus, no Babinski response, no Hoffmann sign. Reflexes unchanged from 06/24.

Special Tests

Right straight leg raise positive at 45°, reproducing the burning leg pain rather than back pain; negative on the left at 80°. Crossed straight leg raise negative. Slump test positive on the right. Femoral stretch test negative bilaterally. Facet loading negative. Gaenslen and thigh thrust negative. **Bicycle test: 6 minutes to symptom onset seated, over 15 minutes standing-flexed** — supportive of a foraminal, position-dependent mechanism.

Neurologic / Safety Findings

Alert and fully oriented, cognition intact with no opioid-related impairment. Coordination normal. **Gait safety is the concern — reduced right toe clearance with one trip in a fortnight represents a fall risk.** No cauda equina signs: perineal sensation intact, no urinary or faecal symptoms, no bilateral deficit. Findings do not require emergency escalation today but do require urgent imaging and expedited review.

PS PROCEDURE SITE / POST-PROCEDURE EXAMINATION

6 PROCEDURE-RELATED FINDINGS

PROCEDURE PERFORMED AND DATE

Bilateral L3, L4, L5 medial branch and L5 dorsal ramus radiofrequency ablation — 06/24/2026, fluoroscopic guidance, 80°C × 90 s per lesion, local anaesthetic only

INJECTION OR DEVICE SITE LOCATION

Six paraspinal entry points, L3–L5 bilaterally

TENDERNESS, BRUISING, SWELLING, ERYTHEMA

None — all six sites fully healed and non-tender

WARMTH, DRAINAGE, BLEEDING, HEMATOMA

None

INFECTION SIGNS

Absent — afebrile, no local or systemic features

NEUROLOGIC STATUS AFTER PROCEDURE

No procedure-attributable deficit. Expected post-ablation dysaesthesia and multifidus deafferentation, resolved by week 3. The new L5 motor and sensory findings are anatomically remote from every lesion site

PAIN RELIEF PERCENTAGE

70% relief of the target axial facet-mediated pain, sustained at 6 weeks

DURATION OF RELIEF

6 weeks and ongoing; expected duration 9–18 months from a technically successful ablation with two concordant positive diagnostic blocks

FUNCTIONAL IMPROVEMENT AFTER PROCEDURE

Standing tolerance, supine sleep, and car transfers all recovered. Sit-to-stand without arm assistance. Lumbar extension improved from 10° to 25° and pain-free

ADVERSE EFFECTS OR COMPLICATIONS

None attributable. No infection, no bleeding, no new deficit at any lesion level, no thermal injury, no post-procedure pain flare beyond the expected 10 days

PATIENT TOLERANCE AND RECOVERY STATUS

Tolerated well without sedation; discharged at 45 minutes. Recovery uncomplicated. She would consent to repeat ablation when the effect wanes

FA PAIN AND FUNCTIONAL ASSESSMENT TOOLS

7 MEASURES USED & INTERPRETATION

NUMERIC PAIN RATING SCALE

Back 2/10 (was 7/10); right leg 5/10 (was 0–2/10); combined average 4.5 (was 7.5)

OSWESTRY DISABILITY INDEX

38% — moderate disability, improved from 54% on 06/24/2026 (a 16-point fall, well beyond the minimal clinically important difference of 10)

PEG SCALE

4.7, improved from 7.3 — pain 4, enjoyment 5, general activity 5

PROMIS PAIN INTERFERENCE

T-score 58, improved from 66

BRIEF PAIN INVENTORY

Severity 4.0 (was 6.5); interference 4.3 (was 7.1)

PAINDETECT

21 — neuropathic component likely, and a new finding; the score was 9 (unlikely) in May

PHQ-9 / GAD-7

PHQ-9 6 (mild, improved from 11); GAD-7 9 (mild-to-moderate, up from 6) — taper-related anxiety

OPIOID RISK ASSESSMENT

Opioid Risk Tool 2 (low). COMM 5 — below the aberrant-behaviour threshold. Unchanged from baseline

NECK DISABILITY INDEX

Not applicable — no cervical complaint

SCORE INTERPRETATION AND FUNCTIONAL GOALS

The scores tell a two-part story that the single pain number conceals: the treated facet pain has responded well and disability has improved by a clinically meaningful margin, while a new neuropathic problem has appeared and driven the PainDETECT from 9 to 21. Prior goals — stand to cook, sleep supine, transfer from a car — all achieved. New goal: restore 800 m walking tolerance and eliminate the trip risk

L LABORATORY AND DIAGNOSTIC RESULTS

8 RESULTS REVIEWED OR ORDERED

Imaging — reviewed and ordered

Lumbar MRI 01/28/2026 reviewed personally, not by report: multilevel facet arthropathy maximal at L4–L5 and L5–S1; **right L4–L5 foraminal disc protrusion contacting the exiting root, with mild-to-moderate right L5–S1 foraminal narrowing**; three-level degenerative disc disease; grade 1 degenerative spondylolisthesis at L4–L5; no significant central canal stenosis. **Repeat lumbar MRI with contrast ordered today, expedited within 7 days** — the 01/2026 study predates the new deficit by 6 months and cannot be relied upon to characterise it. Standing flexion-extension films ordered to reassess the L4–L5 spondylolisthesis for dynamic instability. Fluoroscopy report from 06/24 reviewed and confirms accurate lesion placement at every target.

Electrodiagnostic Testing

EMG and nerve conduction studies ordered, expedited — never previously performed. Two questions: confirm right L5 radiculopathy and localise it, and screen for diabetic peripheral polyneuropathy, which in a 61-year-old with type 2 diabetes and an HbA1c of 7.1% is a genuine confounder for burning distal leg pain. The dermatomal pattern, the positive straight leg raise, and the focal motor deficit all favour radiculopathy, but distinguishing the two changes the treatment entirely.

Laboratory Studies

08/05/2026: HbA1c 7.1%, fasting glucose 128 mg/dL. Complete blood count normal, white cells 6.8. CRP 3 mg/L and ESR 12 mm/hr — **reassuringly normal, arguing against discitis, epidural abscess, or inflammatory arthropathy.** Creatinine 0.88 mg/dL with eGFR above 60 — safe for continued NSAID use with monitoring. Liver enzymes normal. **Coagulation studies normal and she takes no antiplatelet or anticoagulant agent — no peri-procedural hold is required.** Vitamin B12 480 pg/mL and thyroid function normal, excluding two other causes of neuropathy.

Medication / Safety Monitoring

PDMP reviewed today — single prescriber, single pharmacy, no early fills, no sedative co-prescription. Urine drug screen 08/05/2026 consistent with the prescribed regimen: oxycodone and oxymorphone detected, no non-prescribed opioid, benzodiazepine, stimulant, or cannabinoid. Pill count reconciled exactly against the dispensing record. Opioid treatment agreement reviewed and re-signed. Naloxone in date and its use rehearsed with the patient.

Procedure Reports Reviewed

Diagnostic medial branch blocks 02/18/2026 (85% relief, 5 hours) and 03/24/2026 (80% relief, 9 hours). Radiofrequency ablation report 06/24/2026 with fluoroscopic images. Right L4–L5 transforaminal epidural steroid injection 11/2024 (50% relief, 6 weeks). No prior ablation revision.

Prior Records Reviewed

Primary care notes 2022 to date. Orthopedic spine notes 09/2024 to 03/2025. Three physiotherapy discharge summaries. Pain psychology discharge letter 2025. All prior imaging reports and the images themselves. Diabetes clinic letter 05/2026. DEXA 2025. Her own contemporaneous pain and exercise diary, which is detailed and has been genuinely useful.

A ASSESSMENT

9 INTERVENTIONAL PAIN MEDICINE CLINICAL INTERPRETATION

- **Two separate problems, and conflating them would be the error to avoid at this visit. First: successful radiofrequency ablation of bilateral facet-mediated axial low back pain — 70% relief at 6 weeks, Oswestry down 16 points, extension restored from 10° to 25° and pain-free, facet loading tenderness abolished.**

Second: a new right L5 radiculopathy with an objective motor deficit, which is a different diagnosis at a different anatomical site and requires its own work-up.

- **The ablation did not cause the radiculopathy, and the reasoning matters because the patient believes it did.** The medial branches are posterior structures; the lesions were placed accurately per the fluoroscopy record; no lesion approaches the exiting L5 root in the foramen; the onset was 2 weeks after the procedure, outside the window for thermal injury, which presents within days; and the deficit is progressive over a fortnight, which is not a lesion behaviour. The likely explanation is the opposite of iatrogenic: **with her dominant axial pain relieved, she is walking and standing more, and that has unmasked a foraminal stenosis that the 01/2026 MRI already showed and that her 11/2024 transforaminal injection response predicted.** A pre-existing problem revealed by improved function is a good problem, not a complication — but it is now the limiting one.
- **Right L5 radiculopathy, most likely foraminal, with a new and progressive motor deficit: extensor hallucis longus 4/5 and tibialis anterior 4+/5, both 5/5 six weeks ago, with L5 sensory loss, a positive right straight leg raise at 45°, impaired right heel walking, and observed reduced toe clearance.** This is early foot drop. It is not an emergency — there are no cauda equina features, sphincter function is intact, and the deficit is unilateral and partial — but a progressive motor deficit is a time-sensitive finding and cannot be managed on a routine timeline.
- **Anatomical correlation is good but not yet sufficient.** The 01/2026 MRI shows a right L4–L5 foraminal protrusion and right L5–S1 foraminal narrowing, and the flexion-relieved, walking-provoked pattern with the bicycle test result fits a dynamic foraminal mechanism. But that study predates the deficit by 6 months, and imaging a new neurological sign on a 6-month-old scan is not acceptable practice. Repeat imaging plus electrodiagnostic confirmation are both required before any interventional or surgical decision.
- **Diabetic polyneuropathy is a real confounder that must be excluded rather than assumed away.** Burning distal leg pain in a 61-year-old with type 2 diabetes has an obvious alternative explanation. Against it: the symptoms are strictly unilateral, dermatomal, associated with a focal motor deficit and a positive root tension sign, and there is no stocking-distribution sensory loss and no ankle reflex change. Electrodiagnostic studies will settle it, and the PainDETECT rise from 9 to 21 is consistent with either.
- **The opioid taper is going better than the patient believes and should continue.** A 25–30% reduction over 5 weeks with no withdrawal, no increase in back pain, and an improving Oswestry is a successful taper. Her GAD-7 has risen from 6 to 9 — that is taper-related anxiety, not pharmacological failure. **The temptation here is to pause or reverse the taper because of the new leg pain, and that would be a mistake:** opioids are a poor treatment for neuropathic radicular pain, and reversing a working taper to treat the wrong mechanism would undo five weeks of progress. The taper should hold at the current dose while the diagnosis is clarified, then resume — a pause, not a reversal, and the distinction should be made explicit to her.
- **Gabapentin at 900 mg/day is sub-therapeutic and is being blamed for drowsiness at a dose unlikely to have helped.** Either titrate properly toward 1,800–2,400 mg/day in divided doses, or switch. Given her prior duloxetine intolerance from nausea and amitriptyline intolerance from sedation, pregabalin at a low starting dose is the more realistic alternative if gabapentin titration fails.
- **Interventional options for the leg, in order of appropriateness once imaging is available:** a right L5 transforaminal epidural steroid injection is the logical next step, supported by her 50% response to the same intervention in 11/2024, and diagnostic as well as therapeutic. **Her diabetes is not a contraindication but requires planning** — HbA1c 7.1%, glucose monitoring counselling, and a particulate-free steroid at the lowest effective dose. Repeat facet ablation is not indicated: the ablation is still working. Neuromodulation is premature and inappropriate before the structural cause is characterised and surgical options considered.
- **A surgical opinion is now indicated in parallel rather than sequentially.** A progressive motor deficit with foraminal stenosis and a grade 1 degenerative spondylolisthesis is a decompression conversation, and referring only after a failed injection would waste weeks she cannot afford if the weakness continues. Referring in parallel is not an escalation of intent; it is protecting her options.
- **Overall trajectory is genuinely positive and should be stated as such.** Nine kilograms of sustained weight loss, adherent home exercise, a working ablation, a successful taper in progress, a clean urine screen and PDMP, and a 16-point Oswestry improvement. She has a new problem, not a failure of treatment, and the single most important thing she needs to hear today is that distinction.

P PLAN

10 INTERVENTIONAL PAIN MANAGEMENT BY PROBLEM

- **Right L5 radiculopathy — expedited diagnostic work-up, this week:** lumbar MRI with contrast within 7 days; standing flexion-extension radiographs to reassess the L4–L5 spondylolisthesis for dynamic instability; EMG and nerve conduction studies expedited, both to confirm and localise the radiculopathy and to screen for diabetic polyneuropathy. **Interim safety review by telephone in 7 days with a documented motor check**, brought forward immediately if weakness progresses.
- **Right L5 transforaminal epidural steroid injection — planned, contingent on imaging.** To be scheduled within 2–3 weeks once the MRI defines the level, using a non-particulate steroid at the lowest effective dose under fluoroscopic guidance, diagnostic as well as therapeutic. Consent discussion covering the risk of bleeding, infection, transient glucose elevation, headache, and the small risk of neurological injury already begun today and to be completed at the procedure visit. **No repeat facet ablation** — that treatment is working and does not need repeating.
- **Diabetes and peri-procedural planning:** HbA1c 7.1% is acceptable for injection. She has been counselled that steroid will raise her glucose for 3–7 days, instructed to monitor fasting glucose twice daily for a week afterwards, and given a threshold at which to contact her diabetes team. Her primary care physician has been informed. **No anticoagulant or antiplatelet hold is required** — she takes neither, and this has been verified today rather than assumed.
- **Opioid taper — hold, do not reverse.** Maintain oxycodone modified release 10 mg twice daily with 5 mg immediate release as needed, unchanged, until the diagnosis is clarified. **Resume the taper at 10% every 2–3 weeks once the leg pain has a treatment plan**, targeting complete cessation of the immediate-release component first. The rationale — that opioids treat her old pain, not this new one, and that pausing is not failing — was explained explicitly and she was visibly relieved by it. Opioid agreement re-signed, naloxone confirmed in date, safe storage reconfirmed given grandchildren in the house. PDMP and urine drug screening to continue at every visit.
- **Neuropathic medication: titrate gabapentin** from 300 mg three times daily to 600 mg three times daily over 2 weeks, with a further increase to 800 mg three times daily at 4 weeks if tolerated and helping. If the drowsiness persists at the higher dose or benefit remains absent at 4–6 weeks, **cross-taper to pregabalin 25 mg at night, titrated slowly**, chosen because of her nausea with duloxetine and sedation with amitriptyline. Dosing given in writing with a titration calendar.
- **NSAID and analgesic plan:** continue naproxen 500 mg twice daily as needed with food, limited to 3–4 days weekly, with renal function to be rechecked in 3 months given her diabetes and age. Regular paracetamol continued. Topical diclofenac continued for local relief. Advised to **stop naproxen 3 days before any injection**.
- **Surgical opinion — referred today, in parallel rather than after a failed injection.** Spine surgery referral sent with the imaging, the documented motor change from 5/5 to 4/5 over 6 weeks, the gait observation, and the spondylolisthesis, requesting review within 4 weeks and sooner if weakness progresses. The purpose was framed honestly to the patient: an opinion, not a commitment to surgery.
- **Falls and gait safety — acted on today, not deferred:** physiotherapy re-referred urgently for gait retraining, ankle dorsiflexor strengthening, and falls prevention. **An off-the-shelf ankle-foot orthosis has been arranged for trial this week** to address the toe catching directly. Home hazards reviewed — two loose rugs and a poorly lit stair to be removed and improved. Advised to hold a rail on stairs and to avoid ladders and step-stools. **Driving discussed:** right-sided dorsiflexion weakness affects pedal control, and she has agreed to limit driving to short familiar journeys and to stop entirely if the weakness worsens.
- **Conservative and self-management plan:** continue the home exercise programme, which she is genuinely adherent to, with physiotherapy adding a flexion-biased component for the foraminal pattern. Encourage continued weight reduction — 9 kg is a real achievement and directly reduces foraminal loading. Pacing and flexion-relief positioning strategies reinforced. Pain psychology re-referral offered for the taper-related anxiety, which she has accepted.

- **Coordination:** letters to primary care, the diabetes clinic, spine surgery, physiotherapy, and orthotics, all sent today. Nurse-led telephone review at 7 days with a scripted motor and red-flag check.
- **Red flags given verbally and in writing, with emphasis:** attend the emergency department immediately for new bowel or bladder dysfunction, numbness in the saddle or perineal region, weakness in both legs, or an inability to lift the foot at all. Contact the clinic the same day for worsening weakness, a fall, fever, or new severe pain. She repeated all of these back accurately.

F FOLLOW-UP

11 REASSESSMENT PLAN

Follow-up timeframe and purpose

Within 7 days: nurse-led telephone review with a documented motor examination check and red-flag screen; lumbar MRI with contrast and standing flexion-extension films completed; EMG and nerve conduction studies performed; ankle-foot orthosis fitted. **Two weeks:** clinic review with all results to confirm the diagnosis, finalise the transforaminal injection level, and reassess the motor deficit. **Two to three weeks:** right L5 transforaminal epidural steroid injection if imaging supports it. **Four weeks:** spine surgery opinion. **Six weeks post-injection:** review of percent relief, duration, motor recovery, Oswestry, PEG, and PainDETECT, with the opioid taper resumed at that point. Physiotherapy weekly. Renal function at 3 months. Facet ablation response to be reassessed at 6 and 12 months, with repeat ablation planned when relief falls below 50%. PDMP, urine drug screening, and pill count at every visit. **Emergency department immediately** for cauda equina symptoms or complete foot drop; same-day clinic contact for progressive weakness, a fall, or fever.

TB TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT

62 minutes

COUNSELING / COORDINATION OF CARE TIME

24 minutes — explaining the two-problem framing, the taper hold rationale, driving and falls safety, injection consent discussion

RECORDS REVIEW TIME

13 minutes — MRI images reviewed directly, fluoroscopy report, block response history, PDMP, pain diary

PROCEDURE PLANNING TIME

8 minutes — transforaminal level planning, steroid selection, diabetes and bleeding-risk assessment

MEDICATION MANAGEMENT TIME

11 minutes — opioid taper decision, gabapentin titration plan, NSAID and renal monitoring, naloxone check

E/M LEVEL

99215 — established patient, high-complexity medical decision making: chronic illness with progression plus a new problem with a progressive neurological deficit, extensive data review with independent image interpretation, and controlled-substance management

PROCEDURE CODE(S)

None performed today — transforaminal epidural steroid injection to be scheduled and coded separately

IMAGING GUIDANCE CODE(S)

None today

MEDICATION MANAGEMENT / CONTROLLED SUBSTANCE MONITORING

PDMP review, urine drug screen (presumptive, in-office), pill count reconciliation, and opioid treatment agreement review all documented

BASIS FOR BILLING

Medical Decision Making — high complexity, with independent interpretation of imaging and controlled-substance monitoring; time also documented

PRIMARY ICD-10

M54.41 — Lumbago with sciatica, right side, with M51.16 intervertebral disc disorders with radiculopathy, lumbar region

SECONDARY ICD-10

M47.816 spondylosis without myelopathy or radiculopathy, lumbar region; M43.16 spondylolisthesis, lumbar region; G57.91 unspecified mononeuropathy of right lower limb (foot drop, partial); E11.42 type 2 diabetes with diabetic polyneuropathy (to be excluded); Z79.891 long-term (current) use of opiate analgesic; F41.1 generalized anxiety disorder; Z91.199 patient noncompliance not applicable — adherence documented as good

SO PROVIDER SIGN-OFF

PROVIDER NAME	CREDENTIALS	SPECIALTY	DATE	TIME
Marcus Delacroix, MD	MD, DABA, DABPM	Interventional Pain Medicine	08/05/2026	3:21 PM