Policy Statement

NOTE: An intraspinal injection* of opioid or other substance for the purpose of completing a trial for an implantable infusion pump or for immediate post-operative pain control is approvable*.

*See Policy Guidelines section

Indications for Epidural Injections or Selective Nerve Blocks (caudal, interlaminar, and transforaminal) (Injection of local anesthetics with corticosteroids)

- Acute pain or exacerbation of chronic radicular pain with the following clinical timeframes:
  - Neck or back pain with acute radicular pain (Summers 2013):
    - After 2 weeks or more of acute radicular pain that has failed to respond or poorly responded to conservative management unless the medical reason this conservative treatment cannot be done is clearly documented (active components not required) (Manchikanti 2013; Summers 2013); OR
  - Failed back surgery syndrome or epidural fibrosis causing radicular pain (Manchikanti 2013):
    - Typically not done immediately post-surgery. Documentation requires a medical reason that clearly indicates why an injection is needed. (Manchikanti 2013)
    - Patient must engage in some form of other active conservative treatment* for a minimum of 6 weeks in the last 6 months or details of engagement in other forms of active conservative non-operative treatment if the patient had any prior spinal injections prior to epidural injections unless the medical reason this conservative treatment cannot be done is clearly documented (Manchikanti 2013; Summers 2013); OR
  - Spinal stenosis (foraminal, central or disc disease) causing radicular pain (Manchikanti 2013):
    - Patient must engage in some form of other active conservative treatment* for a minimum of 6 weeks in the last 6 months or details of engagement in other forms of active conservative non-operative treatment if the patient had any prior spinal injections prior to epidural injections unless the medical reason this conservative treatment cannot be done is clearly documented; (Manchikanti 2013; Summers 2013); OR
    - Diagnostic transforaminal injection to identify the pain generator for surgical planning (Manchikanti 2013); AND
  - Pain causing functional disability or average pain levels of ≥ 6 on a scale of 0 to 10 (Manchikanti 2013, 2011; NASS 2013, 2012; Summers 2013).

Frequency of Repeat Therapeutic Injections:

- Epidural injections may be repeated only as medically necessary. Each epidural injection requires an authorization and the following criteria must be met for repeat injections:
  - Documented proof that the prior injection had a positive response by significantly decreasing the patient’s pain (at least 30% reduction in pain after initial injections or significant documented functional improvement) (NASS 2013). Or a second injection may be performed at a different spinal level or with a different epidural technique if there is documentation of a question about the pain generator or there is evidence of multilevel pathology (ODG 2017); AND
  - No more than 3 procedures in a 12-week period of time per region with at least 14 days between injections in the initial diagnostic phase. At least 50% or more cumulative pain relief obtained for a minimum of 6 weeks after initial injections (Manchikanti 2013); AND
The patient continues to have ongoing pain or documented functional disability (pain causing functional disability or pain level ≥ 6 on a scale of 0 to 10) (Manchikanti 2013, 2011; NASS 2013; Summers 2013); **AND**

The patient is actively engaged in other forms of active conservative non-operative treatment (unless pain prevents the patient from participating in conservative therapy*) (Qassem 2017; Summers 2013); **AND**

In the first year of treatment, which may include an initial series of 3 injections in the initial diagnostic phase and additional injections in the treatment phase, a total of 6 epidural injections, per region, may be performed (Manchikanti 2013).

 Repeat injections after the initial diagnostic phase should be done at intervals of at least 2 months provided that previous injections resulted in at least 50% relief or functional improvement for at least 2 months and are limited to a maximum total of 4 therapeutic procedures per region per 12 months (Manchikanti 2013; NASS 2013). If special circumstances are documented (e.g., elderly patient with severe spinal stenosis and not an operative candidate) then repeat injections are limited to a maximum of 6 procedures in 12 months (NASS 2013).

**NOTE:** Each epidural injection requires an authorization.

If the neural blockade is applied for different regions, injections may be administered at intervals of no sooner than 7 days for most types of procedures (Manchikanti 2013).

Injecting multiple regions or performing multiple procedures during the same visit may be deemed medically unnecessary unless documentation is provided outlining an unusual situation (ODG 2017).

- No more than 2 levels of transforaminal blocks should be done in one day (ODG 2017).

**Contraindications for Epidural Injections**

- Bleeding diathesis and full anticoagulation (risk of epidural hematoma);
- Severe spinal stenosis resulting in intraspinal obstruction;
- Local infection at injection site;
- Predominantly psychogenic pain;
- Sepsis;
- Hypovolemia;
- Uncontrolled diabetes;
- Uncontrolled glaucoma;
- High concentrations of local anesthetics in patients with multiple sclerosis;
- For diagnosis or treatment of facet mediated pain;
- Known or suspected allergic reaction to steroid medications;
- Spinal infection; **OR**
- Acute fracture.

**Policy Guidelines**

*Conservative Therapy: (Spine) should include a multimodality approach consisting of a combination of active and inactive components. Inactive components, such as rest, ice, heat, modified activities, medical devices, acupuncture and/or stimulators, medications, injections (including trigger point), and diathermy can be utilized. Active modalities may consist of physical therapy, a physician supervised home exercise program**, and/or chiropractic care (Qassem 2017; Summers 2013).

**Home Exercise Program - (HEP) – the following two elements are required to meet guidelines for completion of conservative therapy:**

- Documentation provided of an exercise prescription/plan (Qassem 2017; Sculpo 2001), **AND**
- Follow up with member with documentation provided regarding completion of HEP, (after suitable 6 week period) or inability to complete HEP due to physical reason- i.e. increased pain, inability to physically perform exercises. (Patient inconvenience or
noncompliance without explanation does not constitute “inability to complete” HEP) (Qassem 2017; Summers 2013).

Terminology: Interlaminar Epidural; Selective Nerve Root Injection (transforaminal only); Transforaminal Injection; Injections of Spinal Canal

**Key Primary CPT Codes:**

**Cervical Thoracic Region**
- 62320, 62321, 64479, +64480, 0228T, +0229T

**Lumbar Sacral Region**
- 62322, 62323, 64483, +64484, 0230T, +0231T

**Description**

Therapeutic Spinal Epidural Injections or Select Nerve Root Blocks (Transforaminal) are types of interventional pain management procedures. The therapeutic use of epidural injections is for short-term pain relief associated with acute back pain or exacerbation of chronic back pain. With therapeutic injections a corticosteroid is injected close to the target area with the goal of pain reduction. Epidural injections should be used in combination with other active conservative treatment* modalities and not as stand alone treatment for long-term back pain relief. There are different approaches used when administering spinal epidural injections:

- **Interlaminar** epidural injections, with steroids, access the epidural space between two vertebrae (Interlaminar) to treat cervical, lumbar or thoracic pain with radicular pain. These procedures should be performed using fluoroscopic guidance. Interlaminar epidural injections are the most common type of epidural injection.

- **Transforaminal** epidural injections (also called selective nerve root blocks) access the epidural space via the intervertebral foramen where the spinal nerves exit (cervical, lumbar or thoracic region). It is used both diagnostically and therapeutically. Some studies report lack of evidence and risks of transforaminal epidural injections. These procedures are always aided with fluoroscopic guidance.

- **Caudal** epidural injections, with steroids, are used to treat back and lower extremity pain, accessing the epidural space through the sacral hiatus, providing access to the lower nerve roots of the spine. These procedures should be performed using fluoroscopic guidance. Failed back surgery syndrome is the most common reason for the caudal approach.

**Related Policies**

- N/A

**Benefit Application**

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.
Regulatory Status

- N/A

Rationale

The rationale for the use of spinal epidural injections is that the sources of spinal pain, e.g., discs and joints, are accessible and amendable to neural blockade.

Medical necessity management for epidural injections includes an initial evaluation including history and physical examination and a psychosocial and functional assessment. The following must be determined: nature of the suspected organic problem; non-responsiveness to active conservative treatment*; level of pain and functional disability; conditions which may be contraindications to epidural injections; and responsiveness to prior interventions.

Interventional pain management specialists do not agree on how to diagnose and manage spinal pain; there is a lack of consensus with regards to the type and frequency of spinal interventional techniques for treatment of spinal pain. The American Society of Interventional Pain Physicians (ASIPP) guidelines and International Spine Intervention Society (SIS) guidelines provide an algorithmic approach which provides a step-by-step procedure for managing chronic spinal pain based upon evidence-based guidelines. It is based on the structural basis of spinal pain and incorporates acceptable evidence of diagnostic and therapeutic interventional techniques available in managing chronic spinal pain.

The guidelines and algorithmic approach referred to above include the evaluation of evidence for diagnostic and therapeutic procedures in managing chronic spinal pain and recommendations for managing spinal pain. The Indications and Contraindications presented within this document are based on the guidelines and algorithmic approach. Prior to performing this procedure, shared decision-making between patient and physician must occur, and patient must understand the procedure and its potential risks and results (moderate short-term benefits, and lack of long-term benefits).

Initial Clinical Reviewers (ICRs) and Physician Clinical Reviewers (PCRs) must be able to apply criteria based on individual needs and based on an assessment of the local delivery system.

Additional Information

Hip-spine syndrome - Hip-spine syndrome is a condition that includes both debilitating hip osteoarthritis and low back pain. Abnormal spinal sagittal alignment and difficulty in maintaining proper balance, as well as a wobbling gait, may be caused by severe osteoarthritis of the hip joint. Epidural injections are used to determine a primary pain generator in this condition.

Spondylolisthesis and nerve root irritation - Degenerative lumbar spondylolisthesis is the displacement of a vertebra in the lower part of the spine; one lumbar vertebra slips forward on another with an intact neural arch and begins to press on nerves. The most common cause, in adults, is degenerative disease although it may also result from bone diseases and fractures. Degenerative spondylolisthesis is not always symptomatic. Epidural injections may be used to determine a previously undocumented nerve root irritation as a result of spondylolisthesis.

Lumbar spinal stenosis with radiculitis - Spinal stenosis is narrowing of the spinal column or of the neural foramina where spinal nerves leave the spinal column, causing pressure on the spinal cord. The most common cause is degenerative changes in the lumbar spine. Neurogenic claudication is the most common symptom, referring to “leg symptoms encompassing the buttock, groin and anterior thigh, as well as radiation down the posterior part of the leg to the feet.” In addition to pain, leg symptoms can include fatigue, heaviness, weakness and/or paresthesia. Some patients may also suffer from accompanying back pain. Symptoms are worse...
when standing or walking and are relieved by sitting. Lumbar spinal stenosis is often a disabling condition, and it is the most common reason for lumbar spinal surgery in adults over 65 years. The most common levels of stenosis are L3 through L5, but it may occur at multilevels in some patients. Radiculitis is the inflammation of a spinal nerve root that causes pain to radiate along the nerve paths. Epidural injections help to ascertain the level of the pain generator in this condition.

Postoperative epidural fibrosis - Epidural fibrosis is a common cause of failed back surgery syndrome. With the removal of a disc, the mechanical reason for pain may be removed, but an inflammatory condition may continue after the surgery and may cause pain. Epidural corticosteroids, with their anti-inflammatory properties, are used to treat postoperative fibrosis and may be used along with oral Gabapentin to reduce pain.

Lumbar herniated disc - Epidural steroid injections have been proven to be effective at reducing symptoms of lumbar herniated discs. Evidence shows that they can be successful in 42% to 56% of patients who do not improve after 6 weeks of conservative treatment. Observation and epidural steroid injection are effective nonsurgical treatments for this condition.

Failed back surgery syndrome - Failed back surgery syndrome (FBSS) is characterized by persistent or recurring low back pain, with or without sciatica, following lumbar surgery. The most common cause of FBSS is epidural fibrosis which can be triggered by a surgical procedure such as discectomy. The inflammation resulting from the surgical procedure may start the process of fibrosis and cause pain. Epidural steroid injections are administered to reduce pain.

References

16. ODG - Official Disability Evidence-Based Guideline, 22nd annual edition, 2017

**Documentation for Clinical Review**

Please provide the following documentation (if/when requested):
- History and physical and/or consultation notes including:
  - Conservative treatment(s), duration, and patient response
  - Diagnostic evaluation
  - Functional limitation(s)
- Prior procedure(s) and response (if applicable)
- Radiology report(s)
- Electrodiagnostic studies (if applicable)

**Post Service**
- Procedure report(s)

**Coding**

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of codes does not constitute or imply member coverage or provider reimbursement.

**MN/IE**

The following services may be considered medically necessary in certain instances and investigational in others. Services may be considered medically necessary when policy criteria are met. Services may be considered investigational when the policy criteria are not met or when the code describes application of a product in the position statement that is investigational.

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
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<td>CPT®</td>
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**HCPCS** None

**ICD-10 Procedure** None

### Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Action</th>
<th>Reason</th>
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<tbody>
<tr>
<td>01/01/2017</td>
<td>Adoption of National Imaging Associates (NIA) Clinical Guidelines</td>
<td>Medical Policy Committee</td>
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<tr>
<td>07/01/2018</td>
<td>NIA Clinical Guideline update</td>
<td>Administrative Review</td>
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<tr>
<td>07/01/2019</td>
<td>NIA Clinical Guideline update</td>
<td>Administrative Review</td>
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### Definitions of Decision Determinations

**Medically Necessary:** A treatment, procedure, or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

**Investigational/Experimental:** A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

### Prior Authorization Requirements (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department. Please call (800) 541-6652 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.