BSC_NIA_CG_300	Epidural Spine Injections		
Original Policy Date:	January 1, 2017	**Effective Date:**	July 1, 2024
Section:	2.0 Medicine	**Page:**	Page 1 of 7

Policy Statement

INDICATIONS FOR EPIDURAL SPINE INJECTIONS/NERVE BLOCKS

GENERAL TO ALL CAUDAL, INTERLAMINAL, AND TRANSFORAMINAL INJECTIONS

- Fluoroscopic guidance should be used for caudal and interlaminar injections and is necessary for transforaminal injections.
- For all injections, patients must exhibit pain causing functional disability or average pain level of ≥6 on a scale of 0 to 10 [5, 6, 7] related to the requested spinal region.

TREATMENT PURPOSES

- **Acute pain or exacerbation of chronic radicular pain** [4] **(all of the following must be met):**
  - Neck or back pain with acute radicular symptoms
  - Duration of pain < 3 months
  - Failure to respond to non-operative conservative treatment targeting the requested spinal region for a minimum of 2 weeks unless the medical reason this treatment cannot be done is clearly documented (active therapy components not required) [6]
- **Spinal stenosis causing axial or radicular pain [4] (all of the following must be met):**
  - Failure to respond to non-operative conservative treatment* targeting the requested spinal region for a minimum of six (6) weeks in the last six (6) months unless the medical reason this treatment cannot be done is clearly documented;
    - **OR** details of engagement in ongoing non-operative conservative treatment* if the individual has had prior spinal injections in the same region [5] [8]
- **Failed back surgery syndrome or epidural fibrosis causing axial or radicular pain (<u>all</u> of the following must be met): [4, 9]**
  - Documentation of a medical reason that clearly indicates why an injection is needed (not typically done immediately post-surgery) [5]
  - Failure to respond to non-operative conservative treatment* targeting the requested spinal region for a minimum of six (6) weeks in the last six (6) months unless the medical reason this treatment cannot be done is clearly documented;
    - **OR** details of engagement in ongoing non-operative conservative treatment* if the individual has had prior spinal injections in the same region [6]

DIAGNOSTIC PURPOSES

- **Transforaminal injection to identify the pain generator for surgical planning (<u>all</u> of the following must be met):**
  - Documentation of a pre-operative evaluation and plan for surgery

  NOTE: No more than 2 levels of transforaminal blocks should be done in one day.

REPEAT INJECTIONS

Epidural injections may be repeated only as medically necessary. **<u>Each</u>** epidural injection requires an authorization, and the following criteria must be met for repeat injections:

- Up to 3 epidural injections may be performed in the initial treatment phase, no sooner than 2 weeks apart, provided that at least 30% pain relief or significant documented functional improvement is obtained [7]
  - If an injection during the initial treatment phase is unsuccessful, another injection may be performed at a different level in the **same spinal region** or with a change in technique given there is a question about the pain generator or evidence of multi-level pathology

- Epidural injections may only be repeated after the initial treatment phase if the individual has had at least 50% pain relief or significant documented functional improvement for a **minimum of 2 months** after each therapeutic injection [5]
- The patient:
  - continues to have pain causing functional disability or average pain level ≥ 6 on a scale of 0 to 10 [5, 7] related to the requested spinal region.
  - is engaged in ongoing active conservative treatment, unless the medical reason this treatment cannot be done is clearly documented [10]
- In the first year of treatment, a total of 6 epidural injections may be performed **per spinal region**
  - (this includes up to 3 injections in the initial treatment phase and 3 additional therapeutic injections). [5]
- After the first year of treatment, a maximum of 4 epidural injections may be performed in a 12-month period **per spinal region**. [5, 7]
  - If special circumstances are documented (e.g., elderly individual with severe spinal stenosis and not an operative candidate), then repeat injections are limited to a maximum of 6 epidural injections in a 12-month period per spinal region. [7]
- If different spinal regions are being treated, injections should be administered at intervals of at least 7 days unless a medical reason is provided to necessitate injecting multiple regions on the same date of service (see NOTE). [5]

EXCLUSIONS

These requests are excluded from consideration under this guideline:

- Intrathecal injections for pain or spasticity prior to permanent pump insertion
- Implantation of intrathecal catheters or ports for chemotherapy
- Post-operative pain control
- Caudal or spinal anesthesia for surgery

CONTRAINDICATIONS FOR EPIDURAL SPINAL INJECTIONS

- Active systemic or spinal infection
- Skin infection at the site of needle puncture
- Severe spinal stenosis resulting in intraspinal obstruction

Policy Guidelines

*CONSERVATIVE TREATMENT

Non-operative conservative treatment should include a multimodality approach consisting of at least one (1) active and one (1) inactive component targeting the affected spinal region.

- Active components
  - Physical therapy
  - Physician-supervised home exercise program (HEP)**
  - Chiropractic care [10, 11]
- Inactive components
  - Medications (e.g., NSAIDs, steroids, analgesics)
  - Injections (e.g., epidural steroid injection, selective nerve root block)
  - Medical devices (e.g., TENS unit, bracing)

Failure of conservative treatment* is defined as one of the following:

- Lack of meaningful improvement after a full course of treatment; **OR**
- Progression or worsening of symptoms during treatment; **OR**
- Documentation of a medical reason the member is unable to participate in treatment

Closure of medical or therapy offices, patient inconvenience, or noncompliance without explanation does not constitute "inability to complete" treatment.

****Home Exercise Program (HEP)**
The following two elements are required to meet conservative therapy guidelines for HEP:

- Documentation of an exercise prescription/plan provided by a physician, physical therapist, or chiropractor [10]
  AND
- Follow-up documentation regarding completion of HEP after the required 6-week timeframe or inability to complete HEP due to a documented medical reason (i.e., increased pain or inability to physically perform exercises)

CPT Codes:
Cervical Thoracic Region:

- 62320, 62321, 64479 (+64480)

Lumbar Sacral Region:

- 62322, 62323, 64483 (+64484)

GENERAL INFORMATION
It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.

Description

PURPOSE
This guideline describes indications, contraindications, and exclusions for the performance of epidural spine injections, based on The American Society of Interventional Pain Physicians (ASIPP) recommended algorithmic approach. [4]

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

STATEMENT

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. 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.

SPECIAL NOTE

NEW EPISODES OF CARE

Any injection performed at least two years from prior injections in the same region will be considered a new episode of care and the **initial** injection requirements must be met for approval. Events such as surgery on the same spinal region or any new pathology would also prompt a new episode of care.

SCOPE

This guideline applies to all licensed participating network practitioners who provide this service.

BACKGROUND

MEDICAL NECESSITY

Medical necessity management for epidural injections includes an initial evaluation including history and physical examination as well as 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
- Responsiveness to prior interventions

NOTE: It is generally considered **not medically necessary** to perform multiple interventional pain procedures on the same date of service. Documentation of a medical reason to perform injections in different regions on the same day can be provided and will be considered on a case-by-case basis (e.g., holding anticoagulation therapy on two separate dates creates undue risk for the patient). Different types of injections in the same spinal region (cervical, thoracic, or lumbar) should not be done on the same day with the exception of a facet injection and ESI performed during the same session for a synovial cyst confirmed on imaging.

References

1. Authority WSHC, "Health Technology Assesment - Spinal Injections," [Online]. Available: https://www.hca.wa.gov/assets/program/spinal_injections-rr_final_findings_decision_060216.pdf. [Accessed 2023].
2. Authority WSHC, "Health Technology Reviews - Spinal Injections," [Online]. Available: https://www.hca.wa.gov/about-hca/programs-and-initiatives/health-technology-assessment/spinal-injections. [Accessed 2023].
3. Authority WSHC, "About the Health Care Authority (HCA)," 2023. [Online]. Available: https://www.hca.wa.gov/about-hca.

4. L. Manchikanti, N. Knezevic, A. Navani, P. J. Christo, G. Limerick and A. K. Calodney, "Epidural Interventions in the Management of Chronic Spinal Pain: American Society of Interventional Pain Physicians (ASIPP) Comprehensive Evidence-Based Guidelines," *Pain Physician,* vol. 24, pp. S27-208, 2021.
5. L. Manchikanti, S. Abdi, S. Atluri, R. Benyamin, M. V. Boswell and R. M. Buenaventura, "An Update of Comprehensive Evidence-Based Guidelines for Interventional Techniques in Chronic Spinal Pain. Part II: Guidance and Recommendations," *Pain Physician,* vol. 16, pp. S49-283, 2013.
6. North American Spine Society, "Clinical Guidelines for Diagnosis and Treatment of Lumbar Disc Herniation with Radiculopathy," 2012. [Online]. [Accessed 2023].
7. North American Spine Society, "Lumbar Transforaminal Epidural Steroid Injections: Review and Recommendation Statement," 2013. [Online]. [Accessed 2013].
8. D. Sayed, J. Grider, N. Strand, J. M. Hagedorn, S. Falowski, C. M. Lam, V. T. Francio and D. P. Beall, "The American Society of Pain and Neuroscience (ASPN) Evidence-Based Clinical Guideline of Interventional Treatments for Low Back Pain," *Journal of Pain Research,* vol. 15, 2022.
9. V. J. Orhurhu, R. Chu and J. Gill, "Failed Back Surgery Syndrome," in *StatPearls [Internet]*, Treasure Island, FL: StatPearls Publishing, 2023.
10. Annals of Internal Medicine, "Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians," 2017. [Online].
11. The American College of Radiology, *ACR Appropriateness Criteria Low Back Pain: 2021 Update,* 2021.

Documentation for Clinical Review

Please provide the following documentation:

- 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 (in addition to the above, please include the following):

- 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.

The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.

Type	Code	Description
CPT®	62320	Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
	62321	Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (i.e., fluoroscopy or CT)
	62322	Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
	62323	Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (i.e., fluoroscopy or CT)
	64479	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level
	64480	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
	64483	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level
	64484	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)
HCPCS	None	

Policy History

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

Effective Date	Action
01/01/2017	Adoption of National Imaging Associates (NIA) Clinical Guidelines
07/01/2018	NIA Clinical Guideline update
07/01/2019	NIA Clinical Guideline update
07/01/2020	Annual NIA clinical guideline update
01/01/2021	Coding update
03/01/2021	Annual NIA clinical guideline update. Policy title changed from Spinal Epidural Injections to current one.
01/01/2022	Annual NIA clinical guideline update.
01/01/2023	Annual NIA clinical guideline update.
01/01/2024	Annual NIA clinical guideline update.

Effective Date	Action
07/01/2024	Semi-annual NIA clinical guideline update.

Definitions of Decision Determinations

Medically Necessary: Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

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 and Feedback (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 at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

We are interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration.

For utilization and medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

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.