See Policy CPT/HCPCS CODE section below for any prior authorization requirements

APPLIES TO:

Medicare Only

POLICY CRITERIA

This policy is based on the centers for Medicare & Medicaid Services (CMS) Local Coverage Determination (LCD): Nerve Blockade for Treatment of Chronic Pain and Neuropathy (L35457) and Local Coverage Determination (LCD): Lumbar Epidural Injections (L34980).\(^1\,^2\)

Cervical and Thoracic Epidural Injections

Prior to blockade, all patients with pain complaints require an evaluation that includes, at a minimum, an assessment of the source of the pain and treatment of any underlying pathology. Evaluation must be documented in the patient’s records. In addition, those patients who do not respond to injections or otherwise continue with persistent or poorly responsive pain should be referred for a multi-disciplinary or other collaborative comprehensive evaluation. Only fluoroscopic or CT guidance will be covered for epidural injections.

I. Injections should not be repeated in less than five days.

II. Injections are limited to a total of three in a three to six month period of time and should only be repeated if the injections produced significant and sustained relief documented by objective evidence, including improvements in the ability to perform activities of daily living (ADLs).

III. Steroids should be used only in the presence of radiculopathy. Particulate steroids in the cervical region have been shown to be hazardous.

IV. Provider Qualifications:

A. The CMS Manual System, Pub. 100-8, Program Integrity Manual, Chapter 13, Section 5.1 (http://www.cms.hhs.gov/manuals/downloads/pim83c13.pdf) states that "reasonable and necessary" services are "ordered and/or furnished by qualified personnel." Services will be
considered medically reasonable and necessary only if performed by appropriately trained providers.

B. Patient safety and quality of care mandate that healthcare professionals who perform Nerve Blocks are appropriately trained and/or credentialed by a formal residency/fellowship program and/or are certified by either an accredited and nationally recognized organization or by a post-graduate training course accredited by an established national accrediting body or accredited professional training program. If the practitioner works in a hospital facility at any time and/or is credentialed by a hospital for any procedure, the practitioner must be credentialed to perform the same procedure in the outpatient setting. At a minimum, training must cover and develop an understanding of anatomy and drug pharmacodynamics and kinetics as well as proficiency in diagnosis and management of disease, the technical performance of the procedure and utilization of the required associated imaging modalities.

Lumbar Epidural Injections

For purposes of this policy, a “session” is defined as all epidural or spinal procedures performed on a single calendar day.

V. Indications:
A. Pain associated with:
   1. Herpes Zoster and/or
   2. Suspected radicular pain, based on radiation of pain along the dermatome (sensory distribution) of a nerve and/or
   3. Neurogenic claudication and/or
   4. Low back pain, NPRS ≥ 3/10 (moderate to severe pain) associated with significant impairment of activities of daily living (ADLs) and one of the following:
      a. Substantial imaging abnormalities such as a central disc herniation,
      b. Severe degenerative disc disease or central spinal stenosis.
B. Failure of four weeks (counting from onset of pain) of non-surgical, non-injection care, which includes appropriate oral medication(s) and physical therapy to the extent tolerated. Exceptions to the 4 week wait may include:
   1. Pain from Herpes Zoster
   2. At least moderate pain with significant functional loss at work or home
   3. Severe pain unresponsive to outpatient medical management
   4. Inability to tolerate non-surgical, non-injection care due to co-existing medical condition(s)
   5. Prior successful injections for same specific condition with relief of at least 3 months’ duration

VI. Procedure Requirements:
A. An appropriately comprehensive evaluation of all potential contributing pain generators and treatment in accordance with an established and documented treatment plan.
B. Plain films to rule out red flag conditions may be appropriate if potential issues of trauma, osteomyelitis or malignancy are a concern.
C. Real-time imaging guidance, fluoroscopy or computed tomography, with the use of injectable radio-opaque contrast material is required for all steroid injections and all transforaminal injections. Its use is urged but not required for other epidural injections.

1. Contrast medium should be injected during epidural injection procedures unless patient has contraindication to injection. The reasons for not using contrast must be documented in the procedure report.

2. Films that adequately document final needle position and injectate flow must be retained and made available upon request.

3. For each session, no more than 80mg of triamcinolone, 80 mg of methylprednisolone, 12 mg of betamethasone, 15 mg of dexamethasone or equivalent corticosteroid dosing may be used.

4. When a diagnostic spinal nerve block is performed, post-block assessment of percentage pain relief must be documented.

5. Levels per session:
   a. No more than two transforaminal injections may be performed at a single setting (e.g. single level bilaterally or two levels unilaterally)
   b. One caudal or lumbar interlaminar injection per session and not in conjunction with a lumbar transforaminal injection.

VII. Frequency:

A. No more than 3 epidurals may be performed in a 6-month period of time.

B. No more than 6 epidural injection sessions (therapeutic epidurals and/or diagnostic transforaminal injections) may be performed in a 12-month period of time regardless of the number of levels involved.

C. If a prior epidural provided no relief, a second epidural is allowed following reassessment of the patient and injection technique.

VIII. Local anesthesia or minimal conscious sedation may be appropriate. Use of moderate sedation and Monitored Anesthesia Care (MAC) is usually unnecessary. Documentation must clearly establish the need for such sedation in the specific patient.

IX. Provider Qualifications

A. The CMS Manual System, Pub. 100-8, Program Integrity Manual, Chapter 13, Section 5.1 (http://www.cms.hhs.gov/manuals/downloads/pim83c13.pdf) states that "reasonable and necessary" services are "ordered and/or furnished by qualified personnel." Services will be considered medically reasonable and necessary only if performed by appropriately trained providers.

B. Patient safety and quality of care mandate that healthcare professionals who perform Epidural Steroid Injections are appropriately trained and/or credentialed by a formal residency/fellowship program and/or are certified by either an accredited and nationally recognized organization or by a post-graduate training course accredited by an established national accrediting body or accredited professional training program. If the practitioner works in a hospital facility at any time and/or is credentialed by a hospital for any procedure, the practitioner must be credentialed to perform the same procedure in the outpatient setting. (At a minimum, training must cover and develop an understanding of anatomy and drug pharmacodynamics and kinetics as well as proficiency in diagnosis.
and management of disease, the technical performance of the procedure and utilization of the required associated imaging modalities).

X. Limitations

A. For a patient with low back pain only, a simple disc bulge or annular tear/fissure is insufficient to justify performance of an epidural.

B. Patient must not have major risk factors for spinal cancer (e.g., LBP with fever) or, if cancer is present, but the pain is clearly unrelated, an epidural may be indicated if one of the "Indications" previously listed is present.

C. A co-existing medical or other condition that precludes the safe performance of the procedure precludes coverage of the procedure, e.g., new onset of LBP with fever, risk factors for, or signs of, cauda equina syndrome, rapidly progressing (or other) neurological deficits.

D. Numbness and/or weakness without paresthesiae/dysesthesiae or pain precludes coverage.

E. There is no role for “series of three” epidurals. Response to each epidural should be determined prior to determining the value of a repeat epidural and the specific methods used for subsequent epidurals.

BILLING GUIDELINES

- Convenience kits, such as Dyural 80, are not covered. Physicians are to bill for the steroid medication only. All other costs are procedural expenses.
- Epidural steroid injections using ultrasound guidance is not covered. Therefore, ESI may not be billed using codes 0228T-0231T.

CPT/HCPCS CODES

<table>
<thead>
<tr>
<th>Medicare Only</th>
<th>No Prior Authorization Required</th>
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<tbody>
<tr>
<td><strong>Cervical/Thoracic Region</strong></td>
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<tr>
<td>62320</td>
<td>Injection(s), of diagnostic or therapeutic substance(s) (eg, 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</td>
</tr>
<tr>
<td>62321</td>
<td>Injection(s), of diagnostic or therapeutic substance(s) (eg, 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 (ie, fluoroscopy or CT)</td>
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<tr>
<td>64479</td>
<td>Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level</td>
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PROVIDENCE HEALTH ASSURANCE MEDICAL POLICY

Back: Epidural Steroid Injections (Medicare Only)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>64480</td>
<td>Injection(s), anesthetic agent 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)</td>
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Lumbar Region

<table>
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<tr>
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<th>Description</th>
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<tbody>
<tr>
<td>62322</td>
<td>Injection(s), of diagnostic or therapeutic substance(s) (eg, 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</td>
</tr>
<tr>
<td>62323</td>
<td>Injection(s), of diagnostic or therapeutic substance(s) (eg, 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 (ie, fluoroscopy or CT)</td>
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<tr>
<td>64483</td>
<td>Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level</td>
</tr>
<tr>
<td>64484</td>
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</tr>
</tbody>
</table>

DESCRIPTION

For the purposes of this LCD and consistent with standard community understanding and the recommendations of specialty societies, pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage. Pain is chronic when it has been present, continuously or intermittently, despite therapy for three months or more.

- **Diagnostic** - to determine the source of pain e.g., to identify or pinpoint a nerve that acts as a pathway for pain; to determine the type of nerve that conducts the pain; to distinguish between pain that is central (within the brain and spinal cord) or peripheral (outside the brain and spinal cord) in origin; or to determine whether a neurolytic block or surgical lysis of the nerve should be performed. The type of diagnostic test may include injecting saline to stimulate pain or injecting an anesthetic agent to evaluate the patient’s response, as an initial diagnostic step so that other pain relief options may be considered.

- **Therapeutic** - to treat painful conditions that respond to nerve blocks (e.g., celiac block for pain of pancreatic cancer) and /or “inappropriate” sympathetic nervous system activity. An appropriate injection of local anesthetic induces a temporary interruption in the conduction of impulses by peripheral nerves or nerve trunks. Longer-lasting or permanent blockade may be induced with the injection of neurolytic agents and/or application of thermal (not pulsed) radiofrequency. When blockade has been of value in the relief of acute or chronic cancer related pain, somatic or EPIDURAL blockade may be maintained through the infusion of local anesthetics via indwelling catheter.

Nerve blocks cause the temporary interruption of conduction of impulses in peripheral nerves or nerve trunks by the injection of local anesthetic solutions. Their utility in the diagnosis and treatment of non-neuropathic pain and specific syndromes mediated by sympathetic nervous system over activity has
been established.

Lumbar epidural injections are generally performed to treat pain arising from spinal nerve roots. These procedures may be performed via three distinct techniques, each of which involves introducing a needle into the epidural space by a different route of entry. These are termed the interlaminar, caudal, and transforaminal approaches. The procedures involve the injection of a solution containing local anesthetic with or without corticosteroids.

**INSTRUCTIONS FOR USE**

Providence Health Assurance (PHA) Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. PHA Medical Policies are reviewed annually and are based upon Centers for Medicare & Medicaid (CMS) coverage guidance available as of the last policy update. PHA reserves the right to determine the application of Medical Policies and make revisions to its Medical Policies at any time. Providers will be given at least 60-days’ notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and PHA Medical Policy will be resolved in favor of the coverage agreement.

**REGULATORY STATUS**

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case.

**REFERENCES**
