Back: Intradiscal Injections

PROVIDENCE HEALTH PLANS AND PROVIDENCE HEALTH ASSURANCE MEDICAL POLICY

Effective Date: 1/1/2019

Medical Officer Date

Medical Policy Committee Approved Date: 9/16; 11/17; 12/18

Providence Health Plans and Providence Health Assurance Medical Policy

Section: MED Policy No: 127

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

APPLIES TO:

All lines of business

BENEFIT APPLICATION

Medicaid Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) for coverage determinations.

For other lines of business, refer to the Policy Criteria section below:

POLICY CRITERIA

Intradiscal injections are considered experimental/investigational and are not covered for the treatment of back pain.

CPT/HCPCS CODES

All Lines of Business

Not Covered

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>62292</td>
<td>Injection procedure for chemonucleolysis, including discography, intervertebral disc, single or multiple levels, lumbar</td>
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Unlisted Codes
All unlisted codes will be reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is billed related to services addressed in this policy then it will be denied as Not Covered.

22899    Unlisted procedure, spine
64999    Unlisted procedure, nervous system

Coding Note: Intradiscal injections should not be billed with following codes:

20610    Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance
20611    Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting
62281    Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic

DESCRIPTION

Intradiscal injections are for the purpose of treating discogenic pain. The injections can include various combinations of medications and substances such as steroids, normal saline, anesthetics and platelet rich plasma that may alleviate disc pain.

REVIEW OF EVIDENCE

A review of the ECRI, Hayes, Cochrane, and PubMed databases was conducted regarding the use of intradiscal injections as a treatment for back pain. Below is a summary of the available evidence identified through July of 2016:

Based on current literature, there is insufficient evidence to support the use of intradiscal steroid injection therapy as a treatment of back pain.(1,7)

There is some evidence that several different products such as platelet rich plasma, autologous bone marrow and fibrin sealants may be effective for the treatment of discogenic pain. These studies were limited by small sample size (15-26 patients) and short-term follow-up, as only two studies were longer than 6 months.(3-6) Larger, long-term randomized, controlled trials are needed to establish the safety and efficacy of the use of different products in the intradiscal injection treatment for discogenic pain.

CLINICAL PRACTICE GUIDELINES

Colorado Division of Workers’ Compensation

The 2014 treatment guidelines for low back pain, cervical spine injury, and the 2011 treatment guidelines for chronic pain disorders do not recommend the use of intradiscal steroid injections or intradiscal injections of substances such as bone marrow and stem cells.(8-10)
American College of Occupation and Environmental Medicine

The 2011 American College of Occupation and Environmental Medicine (ACOEM) guidelines for acute, subacute and chronic low back disorders and acute, subacute and chronic cervical and thoracic spine disorders state there is insufficient evidence to make a recommendation because of high potential for harm to patients.\(^{(11,12)}\)

**INSTRUCTIONS FOR USE**

Providence Health Plan (PHP) and 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. PHP and PHA Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. PHP and PHA reserve 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 PHP 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**


