



# CLINICAL GUIDELINES

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## CMM-200 ~ EPIDURAL STEROID INJECTIONS

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eviCore healthcare Clinical Decision Support Tool Diagnostic Strategies: This tool addresses common symptoms and symptom complexes. Imaging requests for individuals with atypical symptoms or clinical presentations that are not specifically addressed will require physician review. Consultation with the referring physician, specialist and/or individual's Primary Care Physician (PCP) may provide additional insight.

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## **CMM-200~Epidural Steroid Injections (ESI)**

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## **CMM-200.1 Definitions**

**Transforaminal epidural steroid injection (ESI)** refers to injection of contrast (absent allergy to contrast), followed by the introduction of a corticosteroid and possibly a local anesthetic by inserting a needle into the neuroforamen under fluoroscopic or computed tomography (CT) guidance,, ventral to the nerve root.

**Selective Nerve Root Block (SNRB)** refers to injection of contrast (absent allergy to contrast) followed by the introduction of a local anesthetic by inserting a needle into the neuroforamen under fluoroscopic or computed tomography (CT) guidance, ventral to the nerve root. SNRB's are commonly referred to as Transforaminal Epidural Steroid Injection (ESI), although technically SNRB's involve the introduction of anesthetic only and are used for diagnostic purposes.

**Interlaminar epidural steroid injection (ESI)** refers to injection of contrast (absent allergy to contrast), followed by the introduction of a corticosteroid and possibly a local anesthetic into the epidural space of the spine either through a paramedian or midline interlaminar approach under fluoroscopic guidance.

**Caudal epidural steroid injection (ESI)** refers to the injection of contrast (absent allergy to contrast), followed by the introduction of corticosteroids and possibly a local anesthetic into the epidural space of the spine by inserting a needle through the sacral hiatus under fluoroscopic guidance into the epidural space at the sacral canal.

**Radiculopathy**, for the purpose of this policy, is defined as the presence of pain resulting in significant functional limitations (i.e., diminished quality of life and impaired, age-appropriate activities of daily living), dysaesthesia(s) or paraesthesia(s) reported by the individual in a specified dermatomal distribution of an involved named spinal root(s) and ONE or MORE of the following:

- Loss of strength of specific named muscle(s) or myotomal distribution(s) demonstrated on detailed neurologic examination (within the prior 3 months) concordant with nerve root compression of the involved named spinal nerve root(s)
- Altered sensation to light touch, pressure, pin prick or temperature demonstrated on a detailed neurologic examination (within the prior 3 months) in the sensory distribution concordant with nerve root compression of the involved named spinal nerve root(s)

- Diminished, absent or asymmetric reflex(es) within the prior 3 months concordant with nerve root compression of the involved named spinal nerve root(s)
  - Either of the following:
    - A concordant radiologist's interpretation of an advanced diagnostic imaging study (MRI or CT) of the spine demonstrating compression of the involved named spinal nerve root(s) (Performed within the prior 12 months)
    - Electrodiagnostic studies (EMG/NCV's) diagnostic of nerve root compression of the involved named spinal nerve root(s). (Performed within the prior 12 months).
- ✓ Radicular pain is pain which radiates to the lower extremity along the course of a spinal nerve root, typically resulting from compression, inflammation and/or injury to the nerve root.

**Radiculitis** is defined, for the purpose of this policy, as radicular pain without objective neurological findings. Radiculitis can be considered as an indication for epidural steroid injections.

**Spinal stenosis** refers to the narrowing of the spinal canal usually due to spinal degeneration that occurs with aging. It may also be the result of spinal disc herniation, osteoarthritis or a tumor. Lumbar spinal stenosis results in low back pain as well as pain or abnormal sensations in the legs, thighs, feet or buttocks, or loss of bladder and bowel control. Neurogenic claudication is often a clinical condition that results from spinal stenosis.

### **CMM-200.2 General Guidelines**

The determination of medical necessity for the performance of a selective nerve root block (SNRB) or a therapeutic epidural steroid injection is always made on a case-by-case basis. Please note this guideline does not apply to epidural injections administered for obstetrical or surgical epidural anesthesia.

An epidural steroid injection without the use of fluoroscopic guidance and the injection of a contrast is **considered not medically necessary**, with the exception of an emergent situation or when fluoroscopy or the injection of contrast is contraindicated.

An epidural steroid injection administered for axial spinal pain without documentation of radiculopathy, myelopathy or myeloradiculopathy is considered not medically necessary.

The use of an indwelling catheter to administer a continuous infusion/intermittent bolus should be limited to use in a hospital setting only. It is inappropriate to represent the use of a catheter for single episode injection(s) that is/are commonly performed in an outpatient setting as an indwelling catheter for continuous infusion/intermittent bolus.

Based on the fact that a caudal epidural steroid injection is not target specific, the injectate is diluted, and the injectate rarely reaches the level above L4-L5, a caudal epidural steroid injection for levels above L4-L5 without a supporting clinical rationale (why it is preferred over translaminar or transforaminal, e.g., status post fusion with anatomical limitations) for alternative approaches, **is considered not medically necessary**.

Repeat epidural steroid injections **are considered not medically necessary** when there is an absence of ANY of the following for  $\geq$  two week duration:

- at least 50% pain relief
- increase in the level of function (i.e., return to work)
- reduction in the use of pain medication and/or additional medical services such as physical therapy/chiropractic care

No more than three (3) epidural steroid injections should be performed per episode of pain and no more than four (4) injections per region per year.

There is insufficient scientific evidence to support the scheduling of a “series-of-three” injection in either a diagnostic or therapeutic approach. The medical necessity of subsequent injections should be evaluated individually and be based on the response of the individual to the previous injection with regard to clinically relevant sustained reductions in pain, decreased need for medication and improvement in the individual’s functional abilities.

There is insufficient scientific evidence to support an epidural steroid injection with ultrasound guidance for any indication. It is considered experimental, investigational or unproven.

### **CMM-200.3 Diagnostic Selective Nerve Root Block (SNRB)**

- ✓ A diagnostic selective nerve root block (SNRB), involving the introduction of anesthetic only, is considered **medically necessary** when attempting to establish the diagnosis of radicular pain or radiculopathy when the diagnosis remains uncertain after standard evaluation (neurologic examination, radiological studies and electrodiagnostic studies) in the following clinical situations:
  - When the physical signs and symptoms differ from that found on imaging studies

- When there is clinical evidence of multi-level nerve root pathology
  - When the clinical presentation is suggestive, but not typical for both nerve root and peripheral nerve or joint disease involvement
  - When the clinical findings are consistent with radiculopathy in a dermatomal distribution, but the imaging studies do not corroborate the findings (positive straight leg raise test)
  - When the individual has had previous spinal surgery.
- ✓ A second selective nerve root block is not recommended if there is inadequate response to the first block as determined by the injectate utilized. If the first injection is performed under fluoroscopy and contrast is used for guidance, a second block is not indicated unless there is evidence of multilevel pathology. In these cases a different level or approach should be proposed. There should be an interval of at least one to two (1 to 2) weeks between injections.
  - ✓ When performing transforaminal blocks (SNRB), no more than two (2) nerve root levels should be injected during the same session/procedure.
  - ✓ The performance of diagnostic selective nerve root blocks is considered **not medically necessary** for all other indications.

#### **CMM-200.4 Epidural Steroid Injections**

(Transforaminal, Interlaminar, or Caudal)

- ✓ An epidural steroid injection is **considered medically necessary** for presumed radiculopathy or radiculitis resulting from disease, injury or surgery that has not responded sufficiently to a reasonable course (four week minimum) of conservative treatment (exercise, physical methods including physical therapy and/or chiropractic care, NSAID's and/or muscle relaxants).
- ✓ An epidural steroid injection is **considered medically necessary** for presumed radicular pain that follows a specified dermatomal distribution of an involved named spinal root(s), with or without motor (muscle) weakness, when there is a positive straight leg raise and/or crossed leg raise test and the individual has not responded sufficiently to a reasonable course (four week minimum) of conservative treatment (exercise, physical methods including physical therapy and/or chiropractic care, NSAID's and/or muscle relaxants).

- ✓ When performing transforaminal epidural steroid injection, no more than two (2) nerve root levels should be injected during the same session/procedure. When performing an interlaminarepidural steroid injection, no more than one (1) interlaminar level should be injected during the same session/procedure.
- ✓ To avoid coming to an improper diagnosis or providing unnecessary treatment, the performance of epidural steroid injection in the same region as other spinal injections is **considered not medically necessary** on the same day of service.
- ✓ Based on the limited long- term benefit of performing an epidural steroid injection as an isolated intervention with regard to pain and improved function, all epidural steroid injections should be performed in conjunction with active rehabilitative care/therapeutic exercise. An epidural steroid injection performed in isolation without the individual participating in an active rehabilitation program/home exercise program/functional restoration program **is considered not medically necessary**.
- ✓ An epidural steroid injection is **considered medically necessary as an initial trial** in an individual with evidence of symptomatic spinal stenosis who meets ALL of the following criteria:
  - Diagnostic evaluation has ruled out other potential causes of pain
  - MRI or CT with or without myelography within the past twelve (12) months demonstrates severe spinal stenosis at the level to be treated
  - Significant functional limitations resulting in diminished quality of life and impaired, age-appropriate activities of daily living
  - Failure of at least four (4) weeks of conservative treatment (e.g., exercise, physical methods including physical therapy and/or chiropractic care, NSAID's and/or muscle relaxants).

## CMM-200.5 Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.

CPT®	Code Description/Definition
<b>62320</b>	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
<b>62321</b>	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)
<b>62322</b>	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
<b>62323</b>	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)
<b>62324</b>	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
<b>62325</b>	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)
<b>62326</b>	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
<b>62327</b>	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)
<b>64479</b>	Injection(s), anesthetic agent and/or steroid, transforaminal epidural; with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level
<b>+64480</b>	Injection(s), anesthetic agent and/or transforaminal epidural with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
<b>64483</b>	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level
<b>+64484</b>	Injection(s), anesthetic agent 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)

CPT®	Codes Considered Experimental, Investigational or Unproven
0228T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or level
0229T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic;each additional level (List separately in addition to code for primary procedure)
0230T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level
0231T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure)
This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules.	

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