CLINICAL GUIDELINES

CMM-200: Epidural Steroid Injections (ESI)

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Clinical guidelines for medical necessity review of Comprehensive Musculoskeletal Management Services.
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CMM-200: Epidural Steroid Injections(ESI)

Definitions

- **Transforaminal epidural steroid injection (TFESI)** is a therapeutic injection of contrast (absent allergy to contrast) performed at a single or multiple spinal levels, 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.
- **Selective Nerve Root Block (SNRB)** is a diagnostic injection of contrast (absent allergy to contrast) of a single nerve root to assist with surgical planning, followed by the introduction of a local anesthetic by inserting a needle into the neuroforamen under fluoroscopic or computed tomography (CT) guidance. SNRBs are erroneously referred to as transforaminal epidural steroid injection (TFESI), although technically SNRBs involve the introduction of anesthetic only and are used for diagnostic purposes.
  - Selective nerve root blocks (SNRBs) performed for the purpose of treating pain (i.e., repeat SNRB at the same level) may be termed therapeutic selective nerve root blocks. There is insufficient evidence to support the clinical utility of therapeutic selective nerve root bocks (SNRBs).
- **Interlaminar epidural steroid injection (ILESI)** is an 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 (CESI)** is an 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, dysesthesia (s), or paresthesia (s) reported by the individual in a level-specific referral pattern of an involved named spinal root(s) causing significant functional limitations (i.e., diminished quality of life and impaired, age-appropriate activities of daily living), and **EITHER** of the following:
  - Documentation of **ONE or MORE** of the following, concordant with nerve root compression of the involved named spinal root(s) demonstrated on a detailed neurologic examination within the prior three (3) months:
    - Loss of strength of specific named muscle(s) or myotomal distribution(s)
    - Altered sensation to light touch, pressure, pin prick or temperature in the sensory distribution
    - Diminished, absent or asymmetric reflex(es)
  - Documentation of **EITHER** of the following performed within the prior 12 months:
    - 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)

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- Electrodiagnostic studies (EMG/NCV's) diagnostic of nerve root compression of the involved named spinal nerve root(s).

- **Radicular pain** is pain which radiates to the 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 on physical examination.
- **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.

General Guidelines

- The determination of medical necessity for the performance of a diagnostic 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 or for perioperative pain management. It only applies to the injection of anesthetic, corticosteroid, and/or contrast agent and not to other injectates including but not limited to Spinraza, chemotherapy, neurolytic substances, antispasmodics, antibiotics, antivirals, biologics (e.g., platelet rich plasma, stem cells, amniotic fluid, etc.), and any other injectates that are not in scope of eviCore's management.
- Benefits, coverage policies, and eligibility issues pertaining to each health plan may take precedence over eviCore's guidelines. Providers are urged to obtain written instructions and requirements directly from each payor.
  - eviCore may direct some prior authorization requests to the health plan (e.g., epidural injections in the clinical context of an implantable intrathecal drug pump for which eviCore is not delegated to prior authorization of the implantable intrathecal drug pump).
- An epidural steroid injection should be performed with the use of fluoroscopic or CT guidance and the injection of a contrast, with the exception of an emergent situation or when fluoroscopic/CT guidance or the injection of contrast is contraindicated (e.g., pregnancy).
- 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.

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- 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.
- When performing transforaminal epidural steroid injections (TFESIs) or diagnostic selective nerve root blocks (SNRBs), no more than two (2) nerve root levels should be injected during the same session/procedure.
- When medical necessity criteria is met, a total of three (3) epidural steroid injections (ESIs) per episode of pain, per region may be performed in six (6) months, not to exceed four (4) epidural steroid injections (ESIs) per region in 12 months.
- Additionally, when medical necessity criteria are met for an initial or repeat cervical/thoracic interlaminar (ILESI) and/or a cervical/thoracic transforaminal epidural steroid injection (TFESI), advanced diagnostic imaging should be performed within 24 months prior to the initial or repeat injection.

Indications: Selective Nerve Root Block (SNRB)

- A diagnostic selective nerve root block (SNRB), performed at a single nerve root, involving the introduction of anesthetic only, is considered **medically necessary** when attempting to establish the diagnosis of radicular pain (including radiculitis) or radiculopathy when the diagnosis remains uncertain after standard evaluation (neurologic examination, radiological studies and electrodiagnostic studies) in **ANY** of 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 level-specific referral pattern of an involved named spinal root(s), but the imaging studies do not corroborate the findings (positive straight leg raise test)
  - When the individual has had previous spinal surgery
  - For the purposes of surgical planning.
- A diagnostic selective nerve root block (SNRB) at a spinal level other than the initial level is considered **medically necessary** when **ALL** of the following criteria are met:
  - A response to the prior block of less than 80% relief based on the injectate utilized
  - Evidence of multilevel pathology
  - It has been at least 7 days since the prior block

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Indications: Epidural Steroid Injections (Transforaminal, Interlaminar, or Caudal)

- An epidural steroid injection (ESI) is considered **medically necessary** for **ANY** of the following:
  - Treatment of presumed radiculopathy when there has been failure of at least six (6) weeks of conservative treatment (e.g., exercise, physical methods including physical therapy and/or chiropractic care, nonsteroidal anti-inflammatory drugs [NSAID's] and/or muscle relaxants).
  - Treatment of presumed radiculitis or radicular pain when **ALL** of the following criteria are met:
    - Radicular pain, with or without motor weakness, which follows a level-specific referral pattern of an involved named spinal root(s)
    - A positive straight leg raise, crossed leg raise, and/or Spurling's
    - Failure of at least six (6) weeks of conservative treatment (e.g., exercise, physical methods including physical therapy and/or chiropractic care, NSAID's and/or muscle relaxants).
  - An initial trial when there is evidence of symptomatic spinal stenosis and **ALL** of the following criteria are met:
    - Diagnostic evaluation has ruled out other potential causes of pain
    - MRI or CT with or without Myelography within the past twelve (12) months demonstrates moderate to 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, NSAIDS, and/or muscle relaxants)
- A transforaminal epidural steroid injection (TFESI) in addition to an intra-articular facet joint injection with synovial cyst aspiration is considered **medically necessary** when **BOTH** of the following criteria are met:
  - Advanced diagnostic imaging studies (e.g., MRI CT, CT myelogram) confirm compression or displacement of the corresponding nerve root by a facet joint synovial cyst
  - Clinical correlation with the individual's signs and symptoms of radicular pain or radiculopathy, based on history and physical examination.
- A repeat epidural steroid injection (ESI) is considered **medically necessary** when at least **TWO** of the following criteria are met for two or more week's duration:
  - 50% or greater relief of radicular pain
  - Increase in the level of function/physical activity (e.g., return to work)
  - Reduction in the use of pain medication and/or additional medical services such as physical therapy/chiropractic care

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Non-Indications: SNRB

- Diagnostic selective nerve root blocks (SNRBs) are considered **not medically necessary** for injectates other than anesthetic, corticosteroid, and/or contrast agent and for any other indication (e.g., post-herpetic neuralgia).
- Therapeutic selective nerve root blocks (SNRBs) (i.e., a repeat SNRB at the same level) are considered **experimental, investigational, or unproven** for any indication.
- A diagnostic selective nerve root block (SNRB) at a spinal level other than the initial level is considered **not medically necessary** for **ALL** of the following:
  - Injectates other than anesthetic, corticosteroid, and/or contrast agent
  - An adequate response to the first block, as determined by the injectate utilized
  - An absence of multilevel pathology when the first injection is performed under fluoroscopy/CT guidance using contrast
  - Repeating diagnostic selective nerve root blocks (SNRBs) more frequently than every seven (7) days

Non-Indications: ESI

- An epidural steroid injection (ESI) performed with ultrasound guidance is considered **experimental, investigational, or unproven**.
- An epidural steroid injection is considered **not medically necessary** for **ALL** of the following:
  - Injectates other than anesthetic, corticosteroid, and/or contrast agent
  - When performed without imaging guidance (i.e., CT, fluoroscopy)
  - Transforaminal epidural steroid injection (TFESI) performed at more than two (2) nerve root levels during the same session/procedure.
  - An interlaminar epidural steroid injection (ILESI), performed at more than a single level during the same session/procedure
  - Epidural steroid injection (ESI) administered in the same region as other spinal injections on the same day of service with the exception of an epidural steroid injection performed with an intra-articular facet joint injection with synovial cyst aspiration in accordance with criteria in CMM-200.4 above.
  - Performed in isolation (i.e., without the individual participating in an active rehabilitation program/home exercise program/functional restoration program)
  - Repeating epidural steroid injections more frequently than every 14 days
  - More than three (3) epidural steroid injections (ESIs) per episode of pain, per region in 6 months
  - More than four (4) epidural steroid injections (ESIs) per region, per 12 months
  - For axial spinal pain (i.e., absence of radiculopathy, myelopathy, myeloradiculopathy)
  - A caudal epidural steroid injection (CESI) for levels above L4-L5 without supporting clinical rationale for use of alternative approaches (e.g., translaminar, transforaminal)
  - Performed for post-herpetic neuralgia

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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
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)
62324	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (i.e., fluoroscopy or CT)
62326	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
62327	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (i.e., fluoroscopy or CT)
64479	Injection(s), anesthetic agent and/or steroid, transforaminal epidural; with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level
+64480	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)
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level
+64484	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in

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	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 thoracic; single 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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