Medical Affairs Policy

**Service:** Back Pain Procedures-Epidural Injections (Caudal Epidural, Selective Nerve Root Block, Transforaminal, Translaminal Epidural Injection, Coccydynia Injections)

*PUM 250-0015*

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<th>Arise/WPS Policy Committee Approval</th>
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<td>Prior Authorization Needed</td>
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**Related Medical Policies:**
Back Pain Procedures-Radiofrequency Ablation, Facet and Other Injections
Non-covered Services and Procedures

**Disclaimer:** This policy is for informational purposes only and does not constitute medical advice, plan authorization, an explanation of benefits, or a guarantee of payment. Benefit plans vary in coverage and some plans may not provide coverage for all services listed in this policy. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and federal law. Some benefit plans administered by the organization may not utilize Medical Affairs medical policy in all their coverage determinations. Contact customer services as listed on the member card for specific plan, benefit, and network status information.

Medical policies are based on constantly changing medical science and are reviewed annually and subject to change. The organization uses tools developed by third parties, such as the evidence-based clinical guidelines developed by MCG Health® to assist in administering health benefits. This medical policy and MCG Health® guidelines are intended to be used in conjunction with the independent professional medical judgment of a qualified health care provider. To obtain additional information about MCG email medical.policies@wpsic.com.

**Description:**
This policy addresses Lumbosacral Epidural Steroid Injection (ESI) and Hardware Injection. For Cervical ESI, and Thoracic ESI, Sacroiliac Joint (SI Joint) injection and Coccydynia Injections, see Limitations of Coverage section. This policy does not address obstetric or surgical anesthetic epidural injection.

An epidural injection is an injection of a medication into the epidural space of the spine. For purposes of this policy, caudal epidural, and selective nerve root block, transforaminal epidural, and translaminal epidural injections are all considered epidural injections. The injection is used to treat swelling, pain, and inflammation associated with physical conditions that affect the spinal cord and/or nerve roots. Local anesthetic, a steroid, or a combination of both can be used. These procedures are aided with fluoroscopic guidance.

There is controversy among interventional pain management specialists regarding how to diagnose and manage spinal pain; there is a lack of consensus with regard to the type and frequency of spinal interventional techniques for treatment of spinal pain. Much of the published evidence is conflicting, limited by the heterogeneous character of the patient populations, variability of treatment methods, variability of procedure (injection method...
and injection site), co-administration of drugs, postoperative evaluation times, and nonstandardization of outcome measures. Randomized Controlled Trials often compare the experimental treatment with a “standard” but also unproven treatment.

Evidence for lumbar epidural injection indicates at least a moderate certainty of moderate benefit in short term management of radicular back pain. Evidence for cervical and thoracic epidural steroid injection demonstrates less than moderate certainty of benefit and lower quality of studies.

Rare but serious complications after spinal and spinal steroid injections include cauda equina syndrome, septic facet joint arthritis, discitis, paraplegia, paraspinal abscess, alterations in blood glucose and Hgb A1C. With steroid injections, there may be a dose dependent suppression of the HPA hypothalamic pituitary adrenal axis lasting between one and three months. In 2014, the Food and Drug Administration (FDA) issued a safety announcement warning of rare but serious adverse events associated with corticosteroids injected into the epidural space. Corticosteroids are not approved by the FDA for injection into the epidural space of the spine.

**Definitions:**

**Interlaminar epidural injections** with steroids, access the epidural space between two vertebrae (Interlaminar) to treat cervical, lumbar or thoracic pain with radicular pain. Interlaminar epidural injections are the most common type of epidural injection.

**Transforaminal epidural injections** (also called selective nerve root blocks) access the epidural space via the intervertebral foramen where the spinal nerves exit the spinal column. They are used both diagnostically and therapeutically.

**Caudal epidural injections**, with steroids, are used to treat back and lower extremity pain, accessing the epidural space through the sacral hiatus, providing access to the lower nerve roots of the spine. Failed back surgery syndrome is the most common reason for the caudal approach.

**Radicular pain** (for purposes of this policy) is pain that radiates from the spine into the extremity along the course of the spinal nerve root; the pain should follow the pattern of the sensory dermatome associated with the nerve root(s) identified. The pain may also be described as a burning or tingling sensation. **Radiculopathy** is a term often used interchangeably with the term radicular pain. **Radiculopathy** is radicular pain accompanied by sensory or motor findings.

**Indications of Coverage:**

- Fluoroscopic guidance is required for epidural injections.
A. Lumbar Epidural Injection: is considered medically necessary if all of the following are documented:

1. Symptoms of lumbosacral radicular pain that follow a dermatomal distribution of the location to be injected.

2. Physical exam findings consistent with radiculopathy (e.g., positive straight leg raising test), diminished sensation, diminished or absent reflex, and/or muscle weakness.

3. Documentation of functional status and average pain levels of ≥ 6 on a scale of 0 to 10, or intermittent or continuous pain causing functional disability.

4. Symptoms that have failed to respond to a six week trial within the last 6 months trial of all of the following:
   
a. Medications such as anti-inflammatory, muscle relaxants, analgesic, opioids, gabapentin.

b. Therapy: Physical therapy/chiropractic manipulations performed, at some point, after the onset of the current episode of symptoms. (Documentation of therapy administered by a Certified Athletic Trainer or regular participation in programs such as the Arthritis Foundation Exercise Program may also meet medical criteria for therapy)

➢ If the above criteria are met, allow one (1) epidural injection, at the lumbosacral spinal nerve level(s) requested

B. Subsequent Epidural Injections: Repeat Lumbosacral Epidural Injection at the same location is considered medically necessary when all of the following are met:

1. The previous injection diminished the pain by at least 50 percent

2. A minimum of 6 weeks has passed since the previous injection

3. Post injection physical therapy, chiropractic or home exercise program to increase range of motion (ROM) and core strength has been attempted.

4. Documentation of functional status compared to the pre injection report
If a limit is not specified in the member’s certificate of coverage, a maximum of three epidural injections regardless of level, location, or side in a twelve month period will be considered medically necessary when criteria are met.

C. Diagnostic Lumbosacral Hardware Injection: A single epidural injection is considered medically necessary for diagnostic purposes prior to spinal surgery including surgery for purposes of removing hardware when all of the following conditions are met: (Note: this will count toward the limit of 3 injections)

1. The patient has been evaluated by a surgeon who has recommended possible surgery

2. All criteria for the specific surgical procedure that is recommended are met

3. There is a discrepancy between clinical findings and imaging studies. For instance: Chronic symptoms in an extremity are described, but the imaging reports do not confirm the presence of nerve root impingement (compression, entrapment, displacement) or irritation that is consistent with the patient’s physical symptoms

4. The injection will be performed at the level that is suspected to be symptomatic or to identify the level of pathology at the site of previous surgery

Limitations of Coverage:

A. Review contract and endorsements for exclusions and prior authorization or benefit requirements.

B. If used for a condition/diagnosis other than is listed in the Indications of Coverage, deny as experimental, investigational, and unproven to affect health outcomes.

C. If used for a condition/diagnosis that is listed in the Indications of Coverage, but the criteria are not met, deny as not medically necessary.

D. If used for Post-herpetic Neuralgia or Reflex Sympathetic Dystrophy (also known as Complex Regional Pain Syndrome), deny as not medically necessary.

E. If a limit is not specified in the member’s certificate of coverage, more than three injections regardless of location and level (including therapeutic and diagnostic) in a 12-month period are considered not medically necessary. A 12-month period begins at the time of the initial injection. Note that a bilateral injection will be counted as two (2) injections.
F. An epidural injection provided less than six (6) weeks after the previous injection is considered not medically necessary.

G. Epidural injections provided without the use of fluoroscopic guidance are not current standard medical practice and are considered not medically necessary.

H. Epidurography is considered a component of an epidural injection according to Correct Coding Initiative (CCI) edits, and is not reimbursed separately.

J. Perioperative epidural injections associated with spinal surgery are considered not medically necessary. If any other pain management therapies (such as, but not limited to trigger point injections, and/or lumbar sympathetic blocks) are performed on the same day as an approved surgical procedure (such as… discectomy), the other pain management treatments are considered not medically necessary.

K. Ultrasound guided epidural injections are considered experimental, investigational, and unproven to affect health outcomes.

L. Cervical Epidural Injection, Thoracic Epidural Injection, and Sacroiliac Joint (SI joint) Epidural Injection and Coccydynia Injections are considered experimental, investigational and unproven to affect health outcomes.

M. Epidural Injection for Non-radiccular Pain is considered experimental, investigational and unproven to affect health outcomes.

N. Epidural Injection of Enbrel (etanercept) is considered experimental, investigational and unproven to affect health outcomes.

O. When a diagnostic procedure is performed, injecting multiple regions or performing multiple procedures is considered not medically necessary.

P. Repeat epidural steroid injection after an ineffective epidural injection at the same level is considered not medically necessary.

**Documentation Required:**

- Office notes
- Documentation of Functional Status pre and post injection which includes:
  - Work status/ Work restrictions
  - Specific Activities of Daily Living (ADL)
  - Current pain medication use
Measurable Physical status indicators (e.g. Range of Motion, Muscle strength)

- Procedure report

References:


18. Up to Date. Subacute and chronic low back pain: nonsurgical interventional treatment. Literature review current through: April 2015. This topic last updated: May 13,2014


References Added 2016:


**Review History:**

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✔ Note: For review/revision history prior to 2014 see previous Medical Policy or Coverage Policy Bulletin

*Approved by the Medical Director*