



MEDICAL POLICY

Date Reviewed: 01/26/01, 02/22/02, 03/22/02, 03/28/03, 03/26/04, 8/27/04, 03/24/06, 11/16/07, 01/23/09, 02/05/10, 01/14/11

Subject: Epidural Injections (Caudal Epidural, Selective Nerve Root Block, Transforaminal Epidural Injection) for Non-Obstetrical/Non-Anesthesia Uses

Description: An epidural injection is an injection of a medication into the epidural space of the spine. The injection is used to treat swelling, pain, and inflammation associated with physical conditions that affect the spinal cord and/or nerve roots. Either a local anesthetic, a steroid, or a combination of both can be used.

Indications of Coverage:

A **series of epidural injections** is considered medically necessary if all of the following are documented:

Symptoms of back pain with pain, numbness, or tingling in at least one extremity that follows a dermatomal distribution (see table at end of this guideline) with a positive nerve root tension test. For example, positive Spurling sign for cervical symptoms, a positive femoral stretch test for L2 - L3 lumbar symptoms, and a positive straight leg raising test for L3 - S1 lumbar symptoms. (There are no radicular symptoms or nerve root tension test for thoracic symptomology.) This guideline does not apply to the use of epidural injections for symptoms due to Postherpetic Neuralgia or Reflex Sympathetic Dystrophy (also known as Complex Regional Pain Syndrome).

Symptoms that have failed to respond to a one month trial of oral anti-inflammatory medication (or other oral analgesic medication if the anti-inflammatory medication is contraindicated), which was used on a regular basis and physical therapy/chiropractic manipulations (a minimum of two visits a week for four weeks) performed after the original date of onset of symptoms. If the symptoms are severe (requiring urgent medical care), the trial of conservative therapy may not be required.

Objective confirmation (MRI, CT Scan, CT Myelogram) documenting spinal pathology (for example, disc disease, central canal or neuroforaminal stenosis, prior spinal surgery) consistent with the dermatome of the symptoms that are described.

If the above criteria are met, allow a series of three epidural injections.

If there have been no other epidural injections in the twelve months preceding the current injection, the current injection is considered the initial injection in a new series of injections, and a series of three injections may be allowed.

Fluoroscopic guidance is required for epidural injections.

A **single transforaminal epidural injection** is considered medically necessary for diagnostic purposes prior to spinal surgery when all of the following conditions are met:

The patient has been evaluated by a surgeon who has recommended surgery

All criteria, other than the imaging criterion, for the specific surgical procedure that is recommended are met

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

The injection will be performed at the level that is suspected to be symptomatic

Limitations of Coverage:

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

If used for a condition/diagnosis other than is listed in the Indications of Coverage, deny as experimental or investigative.

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.

More than three injections in a twelve-month period are considered not medically necessary.

An epidural injection provided less than one week after the previous injection is considered not medically necessary.

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

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

If other pain management injections (sacroiliac joint injections, facet joint injections, medial branch nerve blocks, lumbar sympathetic blocks) are provided on the same date of service as an epidural injection, the other injection is considered not medically necessary.

Documentation Required:

Office notes

Confirmation of the radicular symptoms and anatomic abnormalities associated with the symptoms by objective findings (one of the following: MRI, CT scan, CT Myelogram) is required.

Rationale:

There is minimal peer-reviewed literature reporting on controlled clinical trials evaluating the use of epidural injections, and there are no clinical trials supporting the appropriateness of the generally-accepted standard of three injections in a series. Epidural injections are widely recommended for a variety of spinal pain symptoms; however, they are indicated only for the management of back pain with radicular symptoms. There is insufficient peer-reviewed scientific literature supporting the use of epidural injections in individuals without radicular symptoms or for diagnostic purposes for individuals with spinal pain of an unknown cause.

Epidural injections are generally provided to treat specific spinal pathology related to the individual's symptoms. MRI and CT are types of studies that are routinely performed to identify spinal pathology prior to intervention. Objective confirmation of spinal pathology is required to ensure that another etiology for the reported symptoms is not evident.

It may require more than one epidural injection to effectively manage the individual's symptoms. Repeat injections are not usually indicated unless the individual reports pain relief of at least 50%. Due to complications for repeated injections and repeated administration of steroids, more than three injections in a twelve month period are not standard.

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These guidelines are designed for reference purposes only, do not guarantee coverage, and should not be construed as medical advice. See full Medical Policy Disclaimer.

Approved by the Medical Director

Dermatome Table

Nerve Root	Distribution
C2	Jaw, ears, top of head, posterior head
C3	Upper anterior and posterior neck
C4	Lower anterior and posterior neck and collar area
C5	Anterior chest at the level of the clavicle, lateral upper arm, lateral forearm, lower posterior neck, bicep muscle
C6	Lateral (along the radius) arm and thumb, wrist extensor muscles
C7	Index and long fingers, posterior medial arm, tricep muscle
C8	Lateral (along the ulna) arm, ring and little fingers, finger flexor muscles
T1	Circumferential thorax below the level of the clavicle, medial arm and forearm above the wrist
T2	Circumferential thorax at the level of the axilla
T3	Circumferential thorax below the level of the axilla
T4	Circumferential thorax at the lower level of the pectoralis major
T5	Circumferential thorax at the level of the inframammary line
T6	Circumferential thorax at the level of the upper xiphoid
T7	Circumferential thorax at the level of the lower xiphoid
T8	Circumferentially at the level of the upper abdomen
T9	Circumferentially above the level of the umbilicus
T10	Circumferentially at the level of the umbilicus
T11	Circumferentially below the level of the umbilicus
T12	Circumferentially at the level of the pubic bones
L1	Anterior inguinal region, posterior lower back
L2	Upper medial and lateral thigh, posterior lower back, hip flexor (psoas) muscles
L3	Anterior lower medial and lower lateral thigh, inner leg above and below the knee, posterior back, quadriceps muscles
L4	Anterior lower thigh, anterior knee, inner lower leg and ankle, great toe, posterior back, anterior tibialis muscles
L5	Lateral leg, medial foot, posterior back, hallucis longus muscles
S1	Posterior back, posterior lateral leg, outer ankle, heel, small toe, gastrocnemius muscles
S2	Genitalia, posterior back, posterior medial leg to the ankle
S3	Genitalia, perineum