*National Imaging Associates, Inc. *	
Clinical guidelines: **EPIDURAL SPINE INJECTIONS**	**Original Date: October 2012**
CPT Codes: **Cervical Thoracic Region:** **62320, 62321, 64479 (+64480)** **Lumbar Sacral Region:** **62322, 62323, 64483 (+64484)**	**Last Revised Date: ~~May 2022~~May 2023**
Guideline Number: NIA_CG_300	**Implementation Date: January 2024~~23~~**

GENERAL INFORMATION

It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.

Note: Any injection performed at least two years from prior injections in the same region will be considered a new episode of care and the **INITIAL** injection requirements must be met for approval. Events such as surgery on the same spinal region or any new pathology would also prompt a new episode of care.

INDICATIONS FOR EPIDURAL SPINE INJECTIONS OR SELECTIVE NERVE BLOCKS (Caudal, Interlaminar, Transforaminal)

See LEGISLATIVE REQUIREMENTS for specific mandates in the State of Washington

For the treatment of acute pain or exacerbation of chronic radicular pain[1] ALL of the following must be met:

- Neck or back pain with acute radicular symptoms[2]
- Pain causing functional disability or average pain level~~s~~ of ≥ 6 on a scale of 0 to 10 [2-5]
- Duration of pain < 3 months

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- Failure to respond to non-operative conservative therapy targeting the requested spinal region for a minimum of 2 weeks unless the medical reason this treatment cannot be done is clearly documented (active therapy components not required)[2, 3]

For the treatment of spinal stenosis causing axial or radicular pain[1] ALL of the following must be met:

- Pain causing functional disability or average pain level~~s~~ of ≥ 6 on a scale of 0 to 10 [2-5]
- Failure to respond to non-operative conservative therapy* targeting the requested spinal region for a minimum of 6 weeks in the last 6 months unless the medical reason this treatment cannot be done is clearly documented; OR details of engagement in ongoing non-operative conservative therapy* if the individual has had prior spinal injections in the same region[2, 3]

For the treatment of failed back surgery syndrome or epidural fibrosis causing axial[6, 7] or radicular pain[1] ALL of the following must be met:

- Pain causing functional disability or average pain level~~s~~ of ≥ 6 on a scale of 0 to 10 [2-5]
- Documentation of a medical reason that clearly indicates why an injection is needed (not typically done immediately post-surgery)[3]
- Failure to respond to non-operative conservative therapy* targeting the requested spinal region for a minimum of 6 weeks in the last 6 months unless the medical reason this treatment cannot be done is clearly documented; OR details of engagement in ongoing non-operative conservative therapy* if the individual has had prior spinal injections in the same region[2, 3]

For a diagnostic transforaminal injection to identify the pain generator for surgical planning ALL of the following must be met:

- Pain causing functional disability or average pain level~~s~~ of ≥ 6 on a scale of 0 to 10 [2-5]
- Documentation of a pre-operative evaluation and plan for surgery

NOTE: No more than 2 levels of transforaminal blocks should be done in one day.[8]

~~FREQUENCY OF~~INDICATIONS FOR REPEAT INJECTIONS

Epidural injections may be repeated only as medically necessary. **Each** epidural injection requires an authorization, and the following criteria must be met for repeat injections:

- Up to 3 epidural injections may be performed in the initial treatment phase, no sooner than 2 weeks apart, provided that at least 30% pain relief or significant documented functional improvement is obtained[5]
- If ~~the first~~an injection during the initial treatment phase is unsuccessful, another ~~second~~ injection may be performed at a different ~~spinal~~ level in the **same spinal region** or with

a change in technique given there is a question about the pain generator or evidence of multi-level pathology

- Epidural injections may only be repeated after the initial treatment phase if ~~symptoms return, and~~ the individual has had at least 50% pain relief or significant documented functional improvement for a **minimum of 2 months** after each therapeutic injection[3]
- The individual continues to have pain causing functional disability or average pain level~~s~~ ≥ 6 on a scale of 0 to 10 [2, 3, 5]
- The individual is engaged in ongoing active conservative therapy*, unless the medical reason this treatment cannot be done is clearly documented[2, 9]
- In the first year of treatment, a total of 6 epidural injections may be performed **per spinal region** (this includes a series of 3 injections in the initial treatment phase and 3 additional therapeutic injections)~~-~~.[3]
- ~~Repeat therapeutic injections should not be done more frequently than every 2 months with a~~After the first year of treatment, a maximum of 4 epidural injections may be performed in a 12-month period **per spinal region**.[3, 5] If special circumstances are documented (e.g., elderly individual with severe spinal stenosis and not an operative candidate), then repeat injections are limited to a maximum of 6 epidural injections in a 12-month period per spinal region.[5]
- If different spinal regions are being treated, injections should be administered at intervals of no sooner than 7 days unless a medical reason is provided to necessitate injecting multiple regions on the same date of service (see NOTE).[3]

NOTE: It is generally considered **not medically necessary** to perform multiple interventional pain procedures on the same date of service. Documentation of a medical reason to perform injections in different regions on the same day can be provided and will be considered on a case-by-case basis (e.g~~i.e~~., holding anticoagulation therapy on two separate dates creates undue risk for the patient). Different types of injections in the same spinal region (cervical, thoracic, or lumbar) should not be done on the same day with the exception of a facet injection and ESI performed during~~in~~ the same session for a ~~confirmed~~ synovial cyst confirmed on imaging.

EXCLUSIONS

These requests are excluded from consideration under this guideline:

- Intrathecal injections for pain or spasticity prior to permanent pump insertion
- Implantation of intrathecal catheters or ports for chemotherapy
- Post-operative pain control
- Caudal or spinal anesthesia for surgery

CONTRAINDICATIONS FOR EPIDURAL INJECTIONS

- Active systemic or spinal infection
- Skin infection at the site of needle puncture
- Severe spinal stenosis resulting in intraspinal obstruction

Washington

- **Washington State Health Care Authority Technology Assessment**
  20160318B – Spinal Injections[10, 11]
  Limitations of Coverage*:
    - Therapeutic epidural injections in the lumbar or cervical-thoracic spine for chronic pain are a covered benefit when all of the following conditions are met:
        - For treatment of radicular pain
        - With fluoroscopic guidance or CT guidance
        - After failure of conservative therapy
        - No more than two without clinically meaningful improvement in pain and function; and
        - Maximum of three in six months.
    - Washington State Health Care Authority oversees the Apple Health (Medicaid) program and the Public Employees Benefits Board (PEBB) Program[12]

* This coverage policy does not apply to those with a known systemic inflammatory disease such as: ankylosing spondylitis, psoriatic arthritis or enteropathic arthritis

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BACKGROUND

Therapeutic Spinal Epidural Injections or Select Nerve Root Blocks (Transforaminal) are types of interventional pain management procedures. The therapeutic use of epidural injections is for short-term pain relief associated with acute back pain or exacerbation of chronic back pain. With therapeutic injections, a corticosteroid is injected close to the target area with the goal of pain reduction. Epidural injections should be used in combination with other active conservative treatment* modalities and not as stand-alone treatment for long-term back pain relief. Different approaches used when administering spinal epidural injections[13] include:

- **Interlaminar** epidural injections, with steroids, access the epidural space between two vertebrae (Interlaminar) to treat cervical, lumbar, or thoracic pain with radicular pain.[14] These procedures should be performed using fluoroscopic guidance.[15, 16] 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 (cervical, lumbar/sacral, or thoracic region). It is used both diagnostically and therapeutically.

Some studies report lack of evidence and risks of transforaminal epidural injections.[17] These procedures are always aided with fluoroscopic guidance.[1, 16, 18-21]

- **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. These procedures should be performed using fluoroscopic guidance. Failed back surgery syndrome is the most common reason for the caudal approach.[3, 16, 21-23]

The rationale for the use of spinal epidural injections is that the sources of spinal pain, e.g., discs and joints, are accessible and amendable to neural blockade.

Medical necessity management for epidural injections includes an initial evaluation including history and physical examination as well as a psychosocial and functional assessment. The following must be determined: nature of the suspected organic problem; non-responsiveness to active conservative treatment*; level of pain and functional disability; conditions which may be contraindications to epidural injections; and responsiveness to prior interventions.

Interventional pain management specialists do not agree on how to diagnose and manage spinal pain; there is a lack of consensus with regards to the type and frequency of spinal interventional techniques for treatment of spinal pain. The American Society of Interventional Pain Physicians (ASIPP) guidelines recommend an algorithmic approach which provides a step-by-step procedure for managing chronic spinal pain based upon evidence-based guidelines.[1, 3] This approach is based on the structural basis of spinal pain and incorporates acceptable evidence of diagnostic and therapeutic interventional techniques available in managing chronic spinal pain.

The guidelines and algorithmic approach referred to above include the evaluation of evidence for diagnostic and therapeutic procedures in managing chronic spinal pain and recommendations for managing spinal pain. The Indications and Contraindications presented within this document are based on the guidelines and algorithmic approach. Prior to performing this procedure, shared decision-making between patient and physician must occur, and the patient must understand the procedure and its potential risks and results (moderate short-term benefits, and lack of long-term benefits).

OVERVIEW

***Conservative Therapy -** Non-operative treatment should include a multimodality approach consisting of a combination of active and inactive components. Inactive components can include rest, ice, heat, modified activities, medical devices, acupuncture, stimulators, medications, injections, and diathermy. Active modalities should be region-specific (targeting the cervical, thoracic, or lumbar spine) and consist of physical therapy, a physician-supervised home exercise program**, or chiropractic care.[2, 9, 24]

****Home Exercise Program (HEP) -** The following **two elements are required** to meet guidelines for completion of conservative therapy:

- Documentation of an exercise prescription/plan provided by a physician, physical therapist, or chiropractor[9, 25, 26] ; **AND**
- Follow-up documentation regarding completion of HEP after the required 6-week timeframe or inability to complete HEP due to a documented medical reason (i.e., increased pain or inability to physically perform exercises). Closure of medical offices, closure of therapy offices, patient inconvenience, or noncompliance without explanation does not constitute "inability to complete" HEP.[2, 9]

Terminology - Interlaminar Epidural; Selective Nerve Root Injection (transforaminal only); Transforaminal Injection; Injections of Spinal Canal

Hip-spine syndrome[27-29] - Hip-spine syndrome is a condition that includes both debilitating hip osteoarthritis and low back pain. Abnormal spinal sagittal alignment and difficulty in maintaining proper balance, as well as a wobbling gait, may be caused by severe osteoarthritis of the hip joint. Epidural injections are used to determine a primary pain generator in this condition.

Spondylolisthesis and nerve root irritation[13, 30-33] - Degenerative lumbar spondylolisthesis is the displacement of a vertebra in the lower part of the spine; one lumbar vertebra slips forward on another with an intact neural arch and begins to press on nerves. The most common cause, in adults, is degenerative disease; although, it may also result from bone diseases and fractures. Degenerative spondylolisthesis is not always symptomatic. Epidural injections may be used to determine a previously undocumented nerve root irritation because of spondylolisthesis.

Lumbar spinal stenosis with radiculitis[13, 34, 35] - Spinal stenosis is narrowing of either the spinal column or of the neural foramina where spinal nerves leave the spinal column, causing pressure on the spinal cord. The most common cause is degenerative changes in the lumbar spine. Neurogenic claudication is the most common symptom, with leg symptoms including the buttock, groin, and anterior thigh; however, symptoms may also radiate down along the posterior leg to the foot. In addition to pain, leg symptoms can include fatigue, heaviness, weakness, or paresthesia. Some individuals may also suffer from accompanying back pain. Symptoms are worse when standing or walking and are relieved by sitting. Lumbar spinal stenosis is often a disabling condition, and it is the most common reason for lumbar spinal surgery in adults over 65 years. The most common levels of stenosis are L3 through L5, but it may occur at ~~multilevels~~multilevel in some individuals. Radiculitis is the inflammation of a spinal nerve root that causes pain to radiate along the nerve paths. Epidural injections help to ascertain the level of the pain generator in this condition.

Lumbar herniated disc[36-39] - Epidural steroid injections have been proven to be effective at reducing symptoms of lumbar herniated discs. Observation and epidural steroid injection are effective nonsurgical treatments for this condition.

Postoperative epidural fibrosis[40-42] - Epidural fibrosis is a common cause of failed back surgery syndrome. With the removal of a disc, the mechanical reason for pain may be removed, but an inflammatory condition may continue after the surgery and may cause pain. Epidural

corticosteroids, with their anti-inflammatory properties, are used to treat postoperative fibrosis and may be used along with oral Gabapentin to reduce pain.

Failed back surgery syndrome (FBSS)[21, 43] - Failed back surgery syndrome is characterized by persistent or recurring low back pain, with or without sciatica, following lumbar surgery. The most common cause of FBSS is epidural fibrosis triggered by a surgical procedure such as discectomy. The inflammation resulting from the surgical procedure may start the process of fibrosis and cause pain. Epidural steroid injections are administered to reduce pain.

~~POLICY HISTORY~~

~~Date~~	~~Summary~~
~~2023~~	~~Removed Additional Resources~~
~~May 2022~~	~~Added note to clarify when **INITIAL** injection requirements must be met for approval~~ ~~Reorganized indications for clarity and uniformity~~ ~~Added region-specific wording to conservative treatment requirement (e.g., conservative therapy targeting the requested spinal region)~~ ~~Clarified acute pain as duration less than 3 months~~ ~~Updated Frequency of Repeat Injections section and Removed 'Therapeutic' from Section Title (since up to 3 diagnostic injections are allowed by GL)~~ ~~Exclusions section:~~ ~~Added caudal or spinal anesthesia for surgery~~ ~~Updated intrathecal injections for pain or spasticity prior to permanent pump insertion~~ ~~Updated and simplified contraindications list for epidural injections~~
~~January 2022~~	~~Off-cycle change: Changed pain relief period after initial injection: At least 50% or more pain relief obtained for a minimum of 6 weeks~~ ~~2 months after initial injections (Manchikanti, 2013)~~
~~June 2021~~	~~No changes~~
~~November 2020~~	~~Removed CPT codes 0228T; 0229T; 0230T; 0231T~~
~~October 2020~~	~~Updated background information~~
~~October 2019~~	~~Added 'axial' to specify radicular pain for spinal stenosis~~ ~~Added section on Exclusions~~ ~~For 'frequency of repeat therapeutic injections'~~ ~~Changed diagnostic to therapeutic~~ ~~Removed: ongoing pain or documented functional disability or pain level ≥6 on a scale of 0 to 10~~

~~November 2018~~	• ~~Epidural injections or selective nerve blocks: Added language "active components are not required" to indication: 'After 2 weeks or more of acute radicular pain…'~~ • ~~Added text to specify that the time limitation on multiple ESIs is 'per region'. See indication: "In the first year of treatment, which may include an initial series of 3 injections in the initial diagnostic phase and additional injections in the treatment phase, a total of 6 epidural injections, per region, may be performed"~~ • ~~Frequency of repeat therapeutic injections: Changed 'an injection of opioid' to an 'intraspinal injection of opioid' to clarify~~ • ~~Background section: Added content "Intraspinal Drug Trial in anticipation of implanted infusion pump for spinal drug administration"; Added content on Intraspinal Drug Trials~~ • ~~Overview section: removed examples for 'Home Exercise Program', including 'Yoga, Tai Chi, Aerobic Exercise'~~ • ~~Added and updated references~~

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~~ADDITIONAL RESOURCES~~

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POLICY HISTORY

Date	Summary
May 2023	• Added in references • Removed Additional Resources • Added Legislative language for Washington State
May 2022	• Added note to clarify when **INITIAL** injection requirements must be met for approval • Reorganized indications for clarity and uniformity • Added region-specific wording to conservative treatment requirement (e.g., conservative therapy targeting the requested spinal region) • Clarified acute pain as duration less than 3 months • Updated Frequency of Repeat Injections section and Removed 'Therapeutic' from Section Title (since up to 3 diagnostic injections are allowed by GL) • Exclusions section:

	○ Added caudal or spinal anesthesia for surgery ○ Updated intrathecal injections for pain or spasticity prior to permanent pump insertion • Updated and simplified contraindications list for epidural injections
January 2022	• Off-cycle change: Changed pain relief period after initial injection: At least 50% or more pain relief obtained for a minimum of 6 weeks 2 months after initial injections (Manchikanti, 2013)

~~**Reviewed / Approved by NIA Clinical Guideline Committee**~~

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Disclaimer: *National Imaging Associates, Inc. (NIA) authorization policies do not constitute medical advice and are not intended to govern or otherwise influence the practice of medicine. These policies are not meant to supplant your normal procedures, evaluation, diagnosis, treatment and/or care plans for your patients. Your professional judgement must be exercised and followed in all respects with regard to the treatment and care of your patients. These policies apply to all Evolent Health LLC subsidiaries including, but not limited to, National Imaging Associates ("NIA"). The policies constitute only the reimbursement and coverage guidelines of NIA. Coverage for services varies for individual members in accordance with the terms and conditions of applicable Certificates of Coverage, Summary Plan Descriptions, or contracts with governing regulatory agencies. NIA reserves the right to review and update the guidelines at its sole discretion. Notice of such changes, if necessary, shall be provided in accordance with the terms and conditions of provider agreements and any applicable laws or regulations.*

~~**GENERAL INFORMATION**~~

~~It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.~~

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