



MASSACHUSETTS

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Medical Policy

Epidural Steroid Injections for Neck and Back Pain

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Policy Number: 690

BCBSA Reference Number: 2.01.94

NCD/LCD: Local Coverage Determination (LCD): Lumbar Epidural Injections (L35937)

Related Policies

- Artificial Intervertebral Disc: Lumbar Spine, #[592](#)
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Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Epidural steroid injections performed with fluoroscopic guidance may be considered **MEDICALLY NECESSARY** for the treatment of back pain when the following criteria are met:

- Lumbar or cervical radiculopathy (sciatica) that is not responsive to at least 4 weeks of conservative management; AND
- Persistent pain is present of at least moderate-severe intensity; AND
- Short-term relief of pain is the anticipated outcome.

Conservative nonsurgical therapy for at least 4 weeks should include the following:

- Use of prescription strength analgesics for several weeks at a dose sufficient to induce a therapeutic response
 - Analgesics should include anti-inflammatory medications with or without adjunctive medications such as nerve membrane stabilizers or muscle relaxants AND
- Participation in at least 4 weeks of physical therapy (including active exercise) or documentation of why the patient could not tolerate physical therapy, AND
- Evaluation and appropriate management of associated cognitive and behavioral issues.

Repeat treatment of persistent pain due to radiculopathy/sciatica may be considered **MEDICALLY NECESSARY** under the following conditions:

- Previous epidural steroid injections were successful at relieving pain; AND
- At least 30 days have elapsed since the prior injection; AND

- No more than 6 injections given over a 12 month period.

There is not agreement on the maximum number of injections that should be given in one year. Some experts agree that no more than 3 injections should be given in 1 year, but other experts believe that more than 3 per year can be used safely. None of the expert opinion supported more than 6 injections given over a 12 month period.

Repeat treatment is considered **NOT MEDICALLY NECESSARY** if the initial treatment did not result in substantial pain relief.

Simultaneous treatment of 2 vertebral levels may be considered **MEDICALLY NECESSARY** if criteria are met at each level.

Simultaneous treatment of more than 2 vertebral levels is considered **NOT MEDICALLY NECESSARY**.

Epidural steroid injections are considered **INVESTIGATIONAL** in all other situations, including but not limited to treatment of spinal stenosis and nonspecific low back pain.

The use of fluorography (imaging of the epidural space) as a component of epidural steroid injections is considered **INVESTIGATIONAL**.

Medicare HMO BlueSM and Medicare PPO BlueSM Members

Medical necessity criteria and coding guidance for **Medicare Advantage members living in Massachusetts** can be found through the link below.

[Local Coverage Determinations \(LCDs\) for National Government Services, Inc.](#)

Local Coverage Determination (LCD): Lumbar Epidural Injections (L35937)

Note: To review the specific LCD, please remember to click “accept” on the CMS licensing agreement at the bottom of the CMS webpage.

For medical necessity criteria and coding guidance for **Medicare Advantage members living outside of Massachusetts**, please see the Centers for Medicare and Medicaid Services website at <https://www.cms.gov> for information regarding your specific jurisdiction.

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is not required .
Commercial PPO and Indemnity	Prior authorization is not required .
Medicare HMO BlueSM	Prior authorization is not required .
Medicare PPO BlueSM	Prior authorization is not required .

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above **medical necessity criteria MUST** be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

CPT Codes

CPT codes:	Code Description
62320	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
62321	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)
62322	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
62323	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)

Description

Back Pain

Back pain is an extremely common condition. Most episodes are self-limited and will resolve within one month, but a small percentage will persist and become chronic.¹ Patients with chronic back pain may suffer from a serious disability and may use a high volume of medical services. Despite high utilization, many patients with chronic back pain do not improve with available treatments, including surgical interventions. Therefore, there is a high unmet need to determine the efficacy of different treatments for chronic back pain and to determine which patient populations may benefit from specific interventions. In addition, there has been a proliferation of new technologies, combined with large increases in the number of patients treated and in the intensity of treatment. Therefore, there is a concern for the overtreatment of patients who may not benefit from interventions for back pain.²

Sciatica

Back pain can result from a variety of underlying causes. Sciatica is a subset of low back pain that is associated with irritation of one or more lumbar spinal nerve roots, which results in symptoms of radiculopathy. Symptoms of radiculopathy include pain that radiates down the leg to below the knee, numbness, muscle weakness, and lack of reflexes in a dermatomal distribution.³ Most patients with sciatica respond to conservative care with a resolution of their symptoms within several weeks to several months following onset. In a subset of patients, symptoms, and signs of progressive muscle weakness prompt a more aggressive intervention to prevent permanent dysfunction. In other patients, symptoms persist despite conservative management, without progression of neurologic signs, and further treatment options are sought for pain relief.

Spinal Stenosis

Spinal stenosis is another common source of back pain. Spinal stenosis is caused by the narrowing of the spinal canal due to degenerative changes, leading to impingement of the spinal cord and the spinal nerve roots. Symptoms of spinal stenosis can include back pain, leg pain with exertion (neurogenic claudication), muscle weakness, and sensory deficits. The definitive treatment for spinal stenosis is surgery, which includes decompression of the spinal canal with or without spinal fusion. Epidural steroids may reduce inflammation from pressure on the spinal cord, and thus reduce symptoms of compression.

Nonspecific Low Back Pain

Nonspecific low back pain, sometimes called mechanical low back pain, is diagnosed when no specific etiology of pain can be identified. Although the etiology of nonspecific low back pain is uncertain, many experts feel that the pain is of discogenic origin or due to the painful movement of the vertebrae. In these instances, epidural steroid injections may reduce swelling of the vertebral disc and/or surrounding structures, leading to pain relief.

Treatment

Regardless of specific etiology, conservative management is the first-line treatment for most patients with neck or back pain. Nonsteroidal anti-inflammatory drugs or other analgesics are used for symptom relief. These agents should be used for at least several weeks at a dose sufficient to induce a therapeutic response. Additionally, modification of activity in conjunction with some form of exercise therapy is frequently prescribed early in the course of symptoms and typically involves a physical therapist. For patients with persistent nonradicular back pain, current guidelines recommend interdisciplinary rehabilitation, which is defined as an integrated approach using physical rehabilitation in conjunction with a psychological or psychosocial intervention.¹

For patients who fail conservative therapy, a number of interventional therapies are available, which range from minimally invasive procedures, such as injections, to major surgeries, such as spinal decompression with fusion. Injections can be given in different locations (eg, soft tissues, intraspinal, sacroiliac joints) and can use different therapeutic agents (eg, botulinum toxin, steroids, proteolytic enzymes). Other interventional techniques include radiofrequency ablation, prolotherapy, and chemonucleolysis. Most of these nonsurgical interventions do not have high-quality evidence demonstrating their efficacy.⁴ A number of surgical interventions are available, such as discectomy and spinal fusion, each of which can be performed by a variety of techniques. The decision to undertake surgery is best made in the setting of shared decision making between the patient and surgeon, with thorough consideration given to the risks and benefits of surgery.

Epidural Steroid Injections

Epidural injection therapy is one of several second-line therapies available for patients who fail conservative treatment and is one of the most common modalities used in this group of patients.⁵ Epidural steroid injections are performed by inserting a needle into the space between the dura and ligamentum flavum and injecting a steroid preparation. There is considerable variability in the technical aspects of epidural injections. Several different approaches may be used for entering the epidural space (translaminar, transforaminal, caudal). In addition, epidural steroid injections may be administered with or without fluoroscopic guidance. For example, a national survey published in 2002 reported that 30% of academic institutions and 77% of private practices use fluoroscopy.⁶ Some investigators have estimated that lack of correct needle position in the epidural space may occur in 25% or more of injections administered.² Variability of the technique may also involve factors such as the depth of injection into the epidural space, the volume of injectate, and the filling patterns of the injectate.⁵

Treatment is generally given as one to three injections, each performed at least one month apart. Some experts recommend no more than 3 injections in a 12-month period, owing to concerns about the adverse events of chronic steroid administration, both locally and systemically. Others contend that up to six injections per year are safe.

Summary

Epidural steroid injections (ESIs) are a treatment for neck or back pain that has not responded to conservative measures. Local steroid injections may improve pain by reducing inflammation, thus relieving pressure on nerve roots or other structures that may be the origin of pain.

For individuals who have lumbar or cervical radiculopathy who receive ESI, the evidence includes many small randomized controlled trials (RCTs) and a number of systematic reviews of these RCTs. The relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, medication use, and treatment-related morbidity. The evidence base lacks large-scale, high-quality trials and has a high degree of variability among the available trials in terms of patient populations, epidural injection techniques, and comparison treatments. The results of individual trials are mixed, with some reporting significant benefits for the ESI group and others reporting no benefit. Most systematic reviews did not perform pooled analyses due to the heterogeneity of trials. In the two reviews that reported quantitative results, short-term pain relief at up to six months follow-up was superior in patients treated with epidural steroids. None of the analyses reported long-term benefits for treatment with ESIs. Adverse events were generally mild but not well reported in these trials. Serious adverse events can occur, but their rate is unknown. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have spinal stenosis who receive ESIs, the evidence includes a moderately large RCT, a few small RCTs, and systematic reviews of these RCTs. The relevant outcomes include symptoms, functional outcomes, health status measures, quality of life, medication use, and treatment-related morbidity. The largest RCT and the majority of smaller trials did not report a benefit for ESIs. The evidence is insufficient to determine the effects of technology on health outcomes.

For individuals who have nonspecific low back pain who receive ESIs, the evidence includes a number of small RCTs and systematic reviews of these RCTs. The relevant outcomes include symptoms, functional outcomes, health status measures, quality of life, medication use, and treatment-related morbidity. Most trials were of low quality and did not report a benefit for ESIs. The evidence is insufficient to determine the effects of the technology on health outcomes.

Policy History

Date	Action
12/2020	Epidural steroid injections will not be reimbursed for spinal stenosis and low back pain. Effective 12/1/2020.
12/2019	BCBSA National medical policy review. Description, summary and references updated. Policy statements unchanged.
1/2019	BCBSA National medical policy review. Description, summary and references updated. Policy statements unchanged.
3/2018	Policy title clarified. 3/8/2018
1/2018	New references added from BCBSA National medical policy.
1/2017	Clarified coding information for the 2017 code changes.
1/2016	New references added from BCBSA National medical policy.
3/2015	New medical policy describing medically necessary, not medically necessary and investigational indications. Effective 3/1/2015.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

[Medical Policy Terms of Use](#)

[Managed Care Guidelines](#)

[Indemnity/PPO Guidelines](#)

[Clinical Exception Process](#)

[Medical Technology Assessment Guidelines](#)

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