



## Medical Policy

# Epidural Steroid Injections for Neck and Back Pain

### Table of Contents

- [Policy: Commercial](#)
- [Policy: Medicare](#)
- [Authorization Information](#)
- [Coding Information](#)
- [Description](#)
- [Policy History](#)
- [Information Pertaining to All Policies](#)
- [References](#)

### 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](#)
- Interspinous Fixation - Fusion Devices, [#436](#)
- Interspinous and Interlaminar Stabilization-Distractor Devices-Spacers, [#584](#)
- Image-Guided Minimally Invasive Lumbar Decompression for Spinal Stenosis, [#240](#)

### 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 Blue<sup>SM</sup> and Medicare PPO Blue<sup>SM</sup> 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
<b>Commercial Managed Care (HMO and POS)</b>	Prior authorization is <b>not required</b> .
<b>Commercial PPO and Indemnity</b>	Prior authorization is <b>not required</b> .
<b>Medicare HMO Blue<sup>SM</sup></b>	Prior authorization is <b>not required</b> .
<b>Medicare PPO Blue<sup>SM</sup></b>	Prior authorization is <b>not required</b> .

## 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 1 month, but a small percentage will persist and become chronic.<sup>1</sup> Patients with chronic back pain may suffer from 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 overtreatment of patients who may not benefit from interventions for back pain.<sup>2</sup>

### 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.<sup>3</sup> 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 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. 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 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.<sup>1</sup>

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.<sup>4</sup> 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.<sup>5</sup> 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.<sup>6</sup> Some investigators have estimated that lack of correct needle position in the epidural space may occur in 25% or more of injections administered.<sup>2</sup> 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.<sup>5</sup>

Treatment is generally given as one to 3 injections, each performed at least 1 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 6 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. 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 2 reviews that reported quantitative results, short-term pain relief at up to 6 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. 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. 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
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](#)

## References

1. Chou R, Loeser JD, Owens DK, et al. Interventional therapies, surgery, and interdisciplinary rehabilitation for low back pain: an evidence-based clinical practice guideline from the American Pain Society. *Spine (Phila Pa 1976)*. May 1 2009;34(10):1066-1077. PMID 19363457
2. Benyamin RM, Manchikanti L, Parr AT, et al. The effectiveness of lumbar interlaminar epidural injections in managing chronic low back and lower extremity pain. *Pain Physician*. Jul-Aug 2012;15(4):E363-404. PMID 22828691

3. Pinto RZ, Maher CG, Ferreira ML, et al. Epidural corticosteroid injections in the management of sciatica: a systematic review and meta-analysis. *Ann Intern Med.* Dec 18 2012;157(12):865-877. PMID 23362516
4. Chou R, Atlas SJ, Stanos SP, et al. Nonsurgical interventional therapies for low back pain: a review of the evidence for an American Pain Society clinical practice guideline. *Spine (Phila Pa 1976).* May 1 2009;34(10):1078-1093. PMID 19363456
5. Manchikanti L, Buenaventura RM, Manchikanti KN, et al. Effectiveness of therapeutic lumbar transforaminal epidural steroid injections in managing lumbar spinal pain. *Pain Physician.* May-Jun 2012;15(3):E199-245. PMID 22622912
6. Cluff R, Mehio AK, Cohen SP, et al. The technical aspects of epidural steroid injections: a national survey. *Anesth Analg.* Aug 2002;95(2):403-408, table of contents. PMID 12145061
7. Bhatia A, Flamer D, Shah PS, et al. Transforaminal epidural steroid injections for treating lumbosacral radicular pain from herniated intervertebral discs: a systematic review and meta-analysis. *Anesth Analg.* Mar 2016;122(3):857-870. PMID 26891397
8. Dworkin RH, Turk DC, Wyrwich KW, et al. Interpreting the clinical importance of treatment outcomes in chronic pain clinical trials: IMMPACT recommendations. *J Pain.* Feb 2008;9(2):105-121. PMID 18055266
9. Cohen SP, Hanling S, Bicket MC, et al. Epidural steroid injections compared with gabapentin for lumbosacral radicular pain: multicenter randomized double blind comparative efficacy study. *BMJ.* Apr 16 2015;350:h1748. PMID 25883095
10. Spijker-Huiges A, Winters JC, van Wijhe M, et al. Steroid injections added to the usual treatment of lumbar radicular syndrome: a pragmatic randomized controlled trial in general practice. *BMC Musculoskelet Disord.* Oct 11 2014;15:341. PMID 25304934
11. Manchikanti L, Cash KA, Pampati V, et al. Transforaminal epidural injections in chronic lumbar disc herniation: a randomized, double-blind, active-control trial. *Pain Physician.* Jul-Aug 2014;17(4):E489-501. PMID 25054399
12. Diwan S, Manchikanti L, Benyamin RM, et al. Effectiveness of cervical epidural injections in the management of chronic neck and upper extremity pain. *Pain Physician.* Jul-Aug 2012;15(4):E405-434. PMID 22828692
13. Benyamin RM, Singh V, Parr AT, et al. Systematic review of the effectiveness of cervical epidurals in the management of chronic neck pain. *Pain Physician.* Jan-Feb 2009;12(1):137-157. PMID 19165300
14. Cohen SP, Hayek S, Semenov Y, et al. Epidural steroid injections, conservative treatment, or combination treatment for cervical radicular pain: a multicenter, randomized, comparative-effectiveness study. *Anesthesiology.* Nov 2014;121(5):1045-1055. PMID 25335172
15. Friedly JL, Comstock BA, Turner JA, et al. A randomized trial of epidural glucocorticoid injections for spinal stenosis. *N Engl J Med.* Jul 3 2014;371(1):11-21. PMID 24988555
16. Friedly JL, Comstock BA, Turner JA, et al. Long-term effects of repeated injections of local anesthetic with or without corticosteroid for lumbar spinal stenosis: a randomized trial. *Arch Phys Med Rehabil.* Aug 2017;98(8):1499-1507.e1492. PMID 28396242
17. Staal JB, de Bie R, de Vet HC, et al. Injection therapy for subacute and chronic low-back pain. *Cochrane Database Syst Rev.* Jul 16 2008(3):CD001824. PMID 18646078
18. Koes BW, Scholten RJ, Mens JM, et al. Efficacy of epidural steroid injections for low-back pain and sciatica: a systematic review of randomized clinical trials. *Pain.* Dec 1995;63(3):279-288. PMID 8719528
19. Rathmell JP, Benzon HT, Dreyfuss P, et al. Safeguards to prevent neurologic complications after epidural steroid injections: consensus opinions from a multidisciplinary working group and national organizations. *Anesthesiology.* May 2015;122(5):974-984. PMID 25668411
20. Food and Drug Administration. Epidural Corticosteroid Injection: Drug Safety Communication - Risk of Rare But Serious Neurologic Problems. 2014; <https://naidw.org/groups/viewdiscussion/1595-fda-fda-medwatch-epidural-corticosteroid-injection-drug-safety-communication-risk-of-rare-but-serious-neurologic-problems?groupid=277>. Accessed October 29, 2018.
21. Centers for Disease Control Prevention. Multistate outbreak of fungal infection associated with injection of methylprednisolone acetate solution from a single compounding pharmacy - United States, 2012. *MMWR Morb Mortal Wkly Rep.* Oct 19 2012;61(41):839-842. PMID 23076093

22. Watters WC, 3rd, Resnick DK, Eck JC, et al. Guideline update for the performance of fusion procedures for degenerative disease of the lumbar spine. Part 13: injection therapies, low-back pain, and lumbar fusion. *J Neurosurg Spine*. Jul 2014;21(1):79-90. PMID 24980590
23. Chou R, Hashimoto R, Friedly J, et al. *Pain management injection therapies for low-back pain (Technology Assessment No. ESIB0813)*. Rockville, MD: Agency for Healthcare Research and Quality; 2015.
24. North American Spine Society (NASS). Clinical guidelines for multidisciplinary spine care diagnosis and treatment of lumbar disc herniation with radiculopathy. 2012; <https://www.spine.org/Portals/0/Documents/ResearchClinicalCare/Guidelines/LumbarDiscHerniation.pdf>. Accessed October 29, 2018.
25. North American Spine Society (NASS). Evidence-based clinical guidelines for multidisciplinary spine care: Diagnosis and treatment of degenerative lumbar spinal stenosis. 2011; <https://www.spine.org/Portals/0/Documents/ResearchClinicalCare/Guidelines/LumbarStenosis.pdf>. Accessed October 29, 2018.
26. North American Spine Society (NASS). Lumbar transforaminal epidural steroid injections: Review and recommendation statement. 2013; <https://www.spine.org/Documents/ResearchClinicalCare/LTFESIRReviewRecStatement.pdf>. Accessed October 29, 2018.
27. North American Spine Society (NASS). Cervical epidural steroid injections: Review & recommendation statement. 2011; <https://www.spine.org/Documents/ResearchClinicalCare/CESIRReviewRecStatement.pdf>. Accessed October 29, 2018.
28. American Society of Anesthesiologists Task Force on Chronic Pain Management, American Society of Regional Anesthesia Pain Medicine. Practice guidelines for chronic pain management: an updated report by the American Society of Anesthesiologists Task Force on Chronic Pain Management and the American Society of Regional Anesthesia and Pain Medicine. *Anesthesiology*. Apr 2010;112(4):810-833. PMID 20124882
29. Chou R, Qaseem A, Snow V, et al. Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society. *Ann Intern Med*. Oct 02 2007;147(7):478-491. PMID 17909209
30. Manchikanti L, Abdi S, Atluri S, et al. An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations. *Pain Physician*. Apr 2013;16(2 Suppl):S49-283. PMID 23615883
31. American Academy of Neurology (AAN). AAN Summary of Evidence-Based Guidelines for Clinicians: Use of epidural steroid injections to treat lumbosacral radicular pain. 2007; <https://www.aan.com/Guidelines/Home/GetGuidelineContent/250>. Accessed October 29, 2018.