Medical Policy

Epidural Steroid Injections for Neck and Back Pain

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- Policy: Medicare
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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
- Interspinous Fixation - Fusion Devices, #436
- Interspinous and Interlaminar Stabilization-Distraction 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 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 Determination (LCD): Lumbar Epidural Injections (L35937)](#)

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 for information regarding your specific jurisdiction at [https://www.cms.gov](https://www.cms.gov).

**Prior Authorization Information**

Pre-service approval is required for all inpatient services for all products.

See below for situations where prior authorization may be required or may not be required for outpatient services.

Yes indicates that prior authorization is required.

No indicates that prior authorization is not required.

N/A indicates that this service is primarily

N/A indicates that this service is primarily performed in an inpatient setting.

<table>
<thead>
<tr>
<th>Outpatient</th>
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<tbody>
<tr>
<td>Commercial Managed Care (HMO and POS)</td>
<td>No</td>
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<tr>
<td>Commercial PPO and Indemnity</td>
<td>No</td>
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<tr>
<td>Medicare HMO BlueSM</td>
<td>No</td>
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<tr>
<td>Medicare PPO BlueSM</td>
<td>No</td>
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</table>

**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:

<table>
<thead>
<tr>
<th>CPT codes</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>62320</td>
<td>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</td>
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<tr>
<td>62321</td>
<td>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)</td>
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<td>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</td>
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Description
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.¹ 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 specific patient populations who may benefit from specific interventions. Along with this unmet need for efficacious treatments in patients with chronic back pain, there has been a proliferation of new technologies, and 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.

Back pain can result from a variety of underlying causes. Sciatica is a subset of low back pain that is associated with irritation of 1 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 resolution of their symptoms between several weeks and 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 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, sometimes called mechanical low back pain, is diagnosed when no specific etiology of pain can be identified. While the origin of nonspecific low back pain is not certain, 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.

Regardless of specific etiology, conservative management is the first-line treatment for most patients with back pain. Nonsteroidal anti-inflammatory drugs or other analgesics are used for symptom relief. These agents should be used at a sufficient dose to induce a therapeutic response for at least several weeks. Modification of activity in conjunction with some form of exercise therapy, often involving a physical therapist, is usually also prescribed early in the course of symptoms. 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.

For patients who fail conservative therapy, there are a number of interventional techniques available, ranging 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 efficacy. Numerous different surgical interventions are available, such as discectomy and spinal fusion, each of which can be performed by a variety of different techniques. The decision to undertake surgery is best made in the setting of shared decision making between the patient and surgeon, with thorough considerations of 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 for patients who fail initial conservative treatment. Epidural 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. There are several different approaches possible for entering the epidural space (translaminar, transforaminal, caudal). In addition, the procedure may be performed with or without fluoroscopic guidance. A national survey published in 2002 reported that 30% of academic institutions and 77% of private practices use fluoroscopy. Other authors have estimated that lack of correct needle position in the epidural space may occur in 25% of more injections. Further variability of technique may involve factors such as the depth of injection into the epidural space, volume of injectate, and the filling patterns of the injectate.

Treatment is generally given as 1 to 3 injections, each performed at least 1 month apart. Treatment is generally limited to no more than 3 injections in a 12-month period, owing to concerns about the AEs of chronic steroid administration, both locally and systemically.

Summary

Epidural steroid injections (ESIs) are a treatment for 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.

The evidence for ESIs in patients who have lumbar or cervical radiculopathy 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, techniques of epidural injections, 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 do not perform pooled analyses due to 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 are generally mild, but were not well reported in these trials. Serious adverse events (SAEs) can occur, but the rate of
SAEs is unknown. The evidence is sufficient to determine qualitatively that the technology results in a meaningful improvement in the net health outcome.

The evidence for ESIs in patients who have spinal stenosis includes 1 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 do not report a benefit for ESIs. The evidence is sufficient to determine qualitatively that the technology is unlikely to improve the net health outcome.

The evidence for ESIs in patients who have nonspecific low back pain 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. The majority of trials are of low quality and do not report a benefit for ESIs. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Policy History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>3/2018</td>
<td>Policy title clarified. 3/8/2018</td>
</tr>
<tr>
<td>1/2018</td>
<td>New references added from BCBSA National medical policy.</td>
</tr>
<tr>
<td>1/2017</td>
<td>Clarified coding information for the 2017 code changes.</td>
</tr>
<tr>
<td>1/2016</td>
<td>New references added from BCBSA National medical policy.</td>
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**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**


