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Kaiser Foundation Health Plan of Washington

Clinical Review Criteria
Epidural Steroid Injections

Criteria

For Medicare Members

Source	Policy
CMS Coverage Manuals	None
National Coverage Determinations (NCD)	None
Local Coverage Determinations (LCD)	Epidural Steroid Injections for Pain Management (L39242)
Local Coverage Article (LCA)	Billing and Coding: Epidural Steroid Injections for Pain Management (A58995)

For Non-Medicare Members

MPC approved to adopt the proposed revisions to the existing ESI criteria to include acknowledge the importance of conservative therapy. Changes include the following:

Epidural Steroid Injections (Interlaminar, Caudal, or Transforaminal)

Initial Epidural Steroid Injections (ESI)

Initial Epidural Steroid Injections (ESI) are proven and medically necessary when **ALL of the following** criteria are met:

- One of the five indications below:
  - **Suspected Lumbar Radiculopathy defined as:**
    - Lower extremity pain is > or equal to back pain present in nerve root distribution (e.g., L5, S1, etc.) **PLUS, ONE or MORE**:
      - Positive supine straight leg raising test - radicular leg pain reproduced when the leg is extended >30°(e.g., if patient reported pain down the posterior thigh and lateral calf, expectation is a positive SLR test would reproduce that pain and not cause nonspecific pain like calf tightness or low back pain) OR
      - Motor weakness or sensory loss in a radicular distribution (must be in a specific radicular distribution) OR
      - EMG/NCS confirms acute radiculopathy consistent with the patient's symptoms OR
      - Patient's history or advanced imaging consistent with symptoms described
  - **Suspected Cervical Radiculopathy/Radicular pain defined as**:
    - Pain in a *nerve root* distribution (e.g., C6, C7) OR
    - Motor weakness or persistent sensory loss in a radicular distribution (must be in a specific radicular distribution) OR
    - EMG/NCS confirms acute radiculopathy consistent with the patient's symptoms OR
    - Patient's history or advanced imaging consistent with symptoms described
  - **Suspected Thoracic Radiculopathy/Radicular Pain defined as:**

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        - Band of numbness OR
        - Pain or sensitivity in the thoracic dermatomal distribution OR
        - Patient's history or advanced imaging consistent with symptoms described

    - **Lumbar Radicular Pain (at any level) defined as:**
        - Moderate to severe pain in nerve root distribution (e.g., L5, S1, etc.) **AND**
        - Patient's available history and prior imaging is consistent with radicular pain as the primary etiology

    - **Neurogenic claudication** defined as:
        - Bilateral or unilateral leg pain upon standing and walking that is temporarily relieved by forward flexion or sitting or lying down OR
        - The pain of lumbar stenosis is caused by relative ischemia of the lumbar nerve roots when in an upright position

- Treatment of presumed radiculopathy when there has been failure of at least a *4-week trial* of appropriate conservative management **with BOTH of the following:**
    - Physical Therapy* or home exercise* **AND**
    - Medications (e.g., nonsteroidal anti-inflammatory drugs (NSAIDs) oral or topical or acetaminophen) unless contraindicated

  **If conservative therapy is not appropriate, the medical record must clearly document why such approach is not reasonable.*

- MRI or CT with or without Myelography within the past 24-months demonstrates **ONE of the following:**
    - MRI or CT can be waived for the indication of simple lumbar radicular pain without loss of neurologic function (numbness or weakness) of less than six months duration
    - For an indication of *spinal stenosis*: Imaging consistent with moderate to severe spinal stenosis at the level to be treated for patients with a clinical diagnosis of neurogenic claudication
    - For an indication of *radiculopathy*: Imaging consistent with compression or displacement of the corresponding nerve root **OR**, if imaging does not show compression an EMG consistent with acute nerve impingement

  AND
- None of the contraindications below without documentation of a medically justifiable reason for proceeding **

Repeat Epidural Steroid Injections (ESI)

Repeat Epidural Steroid Injections (ESI) are proven and medically necessary when **the following** criteria are met.

- Pain has returned or deterioration in function has occurred **AND**
- If initial steroid injection was done empirically (without CT or MRI) and patient did not respond adequately, advanced imaging must be done prior to repeat injections **AND**
- Prior injection resulted in less than 50% improvement in pain for two or more weeks and the ESI approach is being changed (intralaminar to transforaminal or vice versa) or a different level is being injected (evidence of nerve root compression by CT, MRI, or EMG is required) **OR**
- Patients condition has declined after patients' initial injection resulted in at least 50% improvement in pain for two or more weeks and **at least ONE of the following:**
    - Increase in the level of function/physical activity (e.g., return to work)
    - Reduction in the use of pain medication and/or additional medical services

  NOTE: Additional epidural injections are ***not*** considered medically necessary if these criteria are not met.

Epidural Steroid Injection (ESI) Limitations

- Maximum of four (4) ESI sessions along the spinal column per year.
    - Definitions:
    - A year: the 12-month period starting from the date of service of the first approved injection
- Maximum of two (2) transforaminal ESI injections in one date of service

****Epidural Steroid Injection (ESI) exclusions/contraindications**

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- Anticoagulated
- Axial back pain (isolated to neck, mid-back, or low back pain)
- Back pain in the setting of acute spinal fractures
- Bleeding disorders that are not reversed
- Systemic bacterial or fungal Infection
- Currently on antibiotics/antifungals for an infection
- Currently on high dose steroids
- Demyelinating disease that is causing radicular symptoms
- Local malignancy
- Other CNS processes which predispose to transverse myelitis (case-by-case)
- Uncontrolled Diabetes

For covered criteria:

If requesting this service (*or these services*), please send the following documentation to support medical necessity:

- Last 6 months of clinical notes from requesting provider &/or specialist (including PT notes)

The following information was used in the development of this document and is provided as background only. It is provided for historical purposes and does not necessarily reflect the most current published literature. When significant new articles are published that impact treatment option, Kaiser Permanente will review as needed. This information is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Background

Epidural steroid injections can serve as both a diagnostic and a therapeutic tool for patients with symptoms related to a disc herniation in the spine. Overall, the volume of evidence for the use of therapeutic epidural injections in the treatment of acute and chronic back pain is large. Clinical studies have shown that epidural steroid injections have provided short-term improvement and may be considered in the treatment of selected patients with radicular pain as part of an active therapy program. There is however insufficient evidence to demonstrate that epidural steroid injections are effective in the treatment of back pain in the absence of radicular symptoms.

References

Washington State Department of Labor & Industries Spinal Injections Coverage Decision. Retrieved 01/26/2023 from https://lni.wa.gov/patient-care/treating-patients/treatment-guidelines-and-resources/_docs/SpinalInjectionsCoverageDecision.pdf

Applicable Codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met

CPT® or HCPCS Codes	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

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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)
62324	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)
62326	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
62327	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)
64479	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level
64480	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
64483	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level
64484	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)
77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)

***Note:** Codes may not be all-inclusive. Deleted codes and codes not in effect at the time of service may not be covered.

****To verify authorization requirements for a specific code by plan type, please use the **Pre-authorization Code Check**.

Date Created	Date Reviewed	Date Last Revised
03/07/2023	03/07/2023[MPC],	07/12/2023

[MPC] Medical Policy Committee

Revision History	Description
03/07/2023	MPC approved to adopt clinical criteria for Epidural Injections. Requires 60-day notice, effective date 08/01/2023.
06/06/2023	MPC approved to adopt the proposed revisions to the existing ESI criteria to include acknowledge the importance of conservative therapy. 60-day notice required, effective date 11/01/2023
07/12/2023	Updated effective date from 8/1/2023 to 8/14/2023 for the 3/7/2023 approved criteria updates.

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