**Medical Coverage Policy |** Epidural Injections for Pain Management

**EFFECTIVE DATE:** 03|01|2024
**POLICY LAST REVIEWED:** 11|15|2023

## OVERVIEW

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.

**Note: This policy is applicable for Commercial Products only. For Medicare Advantage Plans, see the applicable policy in the related policy section.**

## MEDICAL CRITERIA

**Commercial Products**

**Non-specific Low Back Pain**

There is limited evidence that epidural injections for the treatment of non-specific low back pain are effective. The following indications are considered when making coverage determinations:

- Back pain interferes with activities of daily living
- There are no neurologic deficits
- History and physical examination and imaging are non-diagnostic for etiology of pain **AND**

Patient has attempted relief with all of the following:

- NSAIDs or acetaminophen ≥ 3 weeks
- Activity modifications ≥ 6 weeks
- Physical therapy ≥ 6 weeks **AND**

There is continued pain after treatment **AND** none of the following indications are present:

- Local infection at injection site
- Increased intracranial pressure
- Epidural metastases

**Cervical, Thoracic or Lumbar Radiculopathy (unilateral symptoms)**

Epidural injections for cervical, thoracic or lumbar radiculopathy are medically necessary when all of the following criteria are met:

On the Visual Analog Scale, pain is classified as either A or B:

A. Greater than or equal to 7 out of 10 **AND**
   All of the following are present:
   - Unilateral pain in nerve root distribution
   - Pain unrelieved by change in body position
   - Pain interferes with activities of daily living
   - Nerve root compression by imaging or testing **AND**

   None of the following indications are present:
   - Local infection at injection site
   - Increased intracranial pressure
   - Epidural metastases

B. Greater than or equal to 3 and less than 7 out of 10 **AND**
   All of the following are present:

- Unilateral pain in nerve root distribution
- Nerve root compression by imaging or testing **AND**

The pain can be classified by one of the following:

1. Worsening pain despite all of the following conservative treatment:
   - NSAIDs or acetaminophen ≥ 1 week
   - Activity modification ≥ 1 week
   - Physical Therapy ≥ 1 week **OR**
2. Continued pain after all of the following conservative treatment:
   - NSAIDs or acetaminophen ≥ 3 weeks
   - Activity modification ≥ 6 weeks
   - Physical Therapy ≥ 6 weeks

**AND** None of the following indications are present:

- Local infection at injection site
- Increased intracranial pressure
- Epidural metastases

## PRIOR AUTHORIZATION

**Commercial Products**

Prior authorization is recommended for Commercial Products and is obtained via the online tool for participating providers. See Related Policies section.

## POLICY STATEMENT

**Commercial Products**

Epidural injections are considered medically necessary when the medical criteria in this policy has been met. It is recommended that a period of no less than 90 days occurs between injections or no more than 4 injections in a 12-month period.

An approved authorization request will be valid for 4 epidural injections in one 12-month period from the requested date of service. An additional authorization request will be required if a member is to exceed epidural injections in the initially approved 12-month period.

## COVERAGE

Benefits may vary between groups/contracts. Please refer to the appropriate Evidence of Coverage, Subscriber Agreement for the applicable surgery services benefits/coverage.

## BACKGROUND

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. 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, in recent years 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.

Back pain can result from a variety of underlying causes. Radiculopathy is a subset of back pain that is associated with irritation of 1 or more spinal nerve roots. Symptoms of lumbar radiculopathy, which is sometimes known as sciatica, include pain that radiates down the leg to below the knee, numbness, muscle weakness, and lack of reflexes in a dermatomal distribution. Most patients with radiculopathy respond to conservative care with a resolution of their symptoms within several weeks to 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 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, 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 (ESIs) 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 for at least several weeks at a dose sufficient to induce a therapeutic response. Duloxetine or tramadol are recommended second-line pharmacologic therapies by the American College of Physicians. 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, 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 therapies 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. A number of 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 consideration given to the risks and benefits of surgery.

Epidural injection therapy is one of several therapies available for patients who fail conservative treatment and is one of the most common modalities used in this group of patients. 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. Some investigators have estimated that lack of correct needle position in the epidural space may occur in 25% or more of injections administered. 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.

For individuals who have lumbar or cervical radiculopathy who receive ESIs, the evidence includes randomized controlled trials (RCTs) and a number of systematic reviews and meta-analyses 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. Meta-analyses have found reduced pain in the short- and intermediate-term (up to 6 months) with ESI compared with conventional therapy. 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. For thoracic disc herniation, based on one relevant, high-quality RCT of thoracic epidural with fluoroscopic guidance, with or without steroids, the evidence is Level II with moderate to strong recommendation for long-term effectiveness. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have nonspecific low back pain who receive ESIs, the evidence includes systematic reviews of RCTs and nonrandomized studies. 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 that the technology results in an improvement in the net health outcome.

## CODING

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The following CPT code(s) are medically necessary when medical criteria are met:

**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)

**64479** Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level

**64483** Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

Note: The above CPT Codes would not be used for maternity delivery or as an anesthetic for surgical procedures.

## RELATED POLICIES

Prior Authorization via Web-Based Tool for Procedures
Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations

## PUBLISHED

Provider Update, January 2024
Provider Update, July 2023
Provider Update, July 2022
Provider Update, June 2021
Provider Update, January 2021

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