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**POLICY LAST UPDATED:** 01|12|2017

## OVERVIEW

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.

Elective spinal injections, such as epidural steroid injections, should be performed under imaging guidance using fluoroscopy unless contraindicated. Failure to use appropriate imaging may result in inappropriate placement of the medication, thereby decreasing the efficacy of the procedure and increasing the need for additional care.

## PRIOR AUTHORIZATION

Prior authorization is not required.

## POLICY STATEMENT

### BlueCHiP for Medicare and Commercial Products

Epidural steroid injection without imaging guidance, is considered not medically necessary as there is insufficient peer-reviewed scientific literature that demonstrates that the procedure/service is effective.

## MEDICAL CRITERIA

Not applicable

## COVERAGE

Benefits may vary between groups/contracts. Please refer to the appropriate section of the Benefit Booklet, Evidence of Coverage, or Subscriber Agreement for services not medically necessary.

## 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. 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. Most patients with sciatica respond to conservative care with 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 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. 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.

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. 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.

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 (e.g., soft tissues, intraspinal, sacroiliac joints) and can use different therapeutic agents (e.g., 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 Steroid Injections**

Epidural steroid 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. ESIs 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, ESIs may be administered with or without fluoroscopic guidance. For example, a national survey published in 2002<sup>6</sup> reported that 30% of academic institutions and 77% of private practices use fluoroscopy. Some authors have estimated that lack of correct needle position in the epidural space may occur in 25% or more of injections administered. Variability of technique may also 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. 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. However, other experts believe that up to 6 injections per year is safe.

Elective spinal injections, such as ESIs, should be performed under imaging guidance using fluoroscopy or CT with contrast enhancement (unless contraindicated) to ensure correct placement of the needle and to maximize diagnostic accuracy and therapeutic efficacy. Failure to use appropriate imaging may result in inappropriate placement of the medication, thereby decreasing the efficacy of the procedure and increasing the need for additional care.

## **CODING**

### **BlueCHiP for Medicare and Commercial Products**

The following codes are not medically necessary:

**62320** Injection(s), of diagnostic or therapeutic substance(s) (e.g., 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

**62322** Injection(s), of diagnostic or therapeutic substance(s) (e.g., 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

**62324** Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance

**62326** Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance

## **RELATED POLICIES**

Preauthorization via Web-Based Tool for Procedures

## **PUBLISHED**

Provider Update, April 2017

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