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| MEDICAL POLICY | Back: Epidural Steroid Injections (Medicare Only) |
| Effective Date: 12/1/2021  12/1/2021 | Medical Policy Number: 17 |
| | Medical Policy Committee Approved Date: 6/17; 12/18; 8/19; 11/2020; 11/2021 |
| Medical Officer | Date |

See Policy CPT/HCPCS CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

APPLIES TO:

Medicare Only

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

| Service | Medicare Guidelines |
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| <i>Cervical and Thoracic Epidural Injections</i> | Local Coverage Determination (LCD): Nerve Blockade for Treatment of Chronic Pain and Neuropathy (L35457) |
| <i>Lumbar Epidural Injections</i> | Local Coverage Determination (LCD): Lumbar Epidural Injections (L34980) |

*In the absence of a Medicare coverage policy or guidance (e.g., manual, national coverage determination [NCD], local coverage determination [LCD] article [LCA], etc.), Medicare guidelines allow a Medicare Advantage Organization (MAO) to make coverage determinations, applying an objective, evidence-based process, based on authoritative evidence. (Medicare Managed Care Manual, Ch. 4, §90.5) Therefore, the commercial medical policy, (**Back: Epidural Steroid Injections (All Lines of Business Except Medicare)**), applies to the following services:*

- Epidural steroid injections with ultrasound guidance (0228T-0231T)
- Isolated central spinal stenosis
- Chemical radiculitis caused by annular tears
- Post-operative pain relief from spinal fusion and/or discectomy/laminectomy

BILLING GUIDELINES

See associated local coverage articles (LCAs) for additional coding and billing guidance:

- LCA: Billing and Coding: Nerve Blockade for Treatment of Chronic Pain and Neuropathy ([A52725](#))
- LCA: Billing and Coding: Lumbar Epidural Injections ([A57203](#))

CPT/HCPCS CODES

| Medicare Only | |
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| No Prior Authorization Required | |
| Cervical/Thoracic Region | |
| 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) |
| 64479 | Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level |
| 64480 | Injection(s), anesthetic agent 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) |
| Lumbar Region | |
| 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) |
| 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, |

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| | 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) |
| 64483 | Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level |
| 64484 | Injection(s), anesthetic agent 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) |
| Not Covered | |
| 0228T | CODE TERMED 12/31/2020 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level |
| 0229T | CODE TERMED 12/31/2020 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure) |
| 0230T | CODE TERMED 12/31/2020 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level |
| 0231T | CODE TERMED 12/31/2020 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure) |

DESCRIPTION

For the purposes of this LCD and consistent with standard community understanding and the recommendations of specialty societies, pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage. Pain is chronic when it has been present, continuously or intermittently, despite therapy for three months or more.

- Diagnostic - to determine the source of pain e.g., to identify or pinpoint a nerve that acts as a pathway for pain; to determine the type of nerve that conducts the pain; to distinguish between pain that is central (within the brain and spinal cord) or peripheral (outside the brain and spinal cord) in origin; or to determine whether a neurolytic block or surgical lysis of the nerve should be performed. The type of diagnostic test may include injecting saline to stimulate pain or injecting an anesthetic agent to evaluate the patient's response, as an initial diagnostic step so that other pain relief options may be considered.

- Therapeutic - to treat painful conditions that respond to nerve blocks (e.g., celiac block for pain of pancreatic cancer) and /or “inappropriate” sympathetic nervous system activity. An appropriate injection of local anesthetic induces a temporary interruption in the conduction of impulses by peripheral nerves or nerve trunks. Longer-lasting or permanent blockade may be induced with the injection of neurolytic agents and/or application of thermal (not pulsed) radiofrequency. When blockade has been of value in the relief of acute or chronic cancer related pain, somatic or EPIDURAL blockade may be maintained through the infusion of local anesthetics via indwelling catheter.

Nerve blocks cause the temporary interruption of conduction of impulses in peripheral nerves or nerve trunks by the injection of local anesthetic solutions. Their utility in the diagnosis and treatment of non-neuropathic pain and specific syndromes mediated by sympathetic nervous system over activity has been established.

Lumbar epidural injections are generally performed to treat pain arising from spinal nerve roots. These procedures may be performed via three distinct techniques, each of which involves introducing a needle into the epidural space by a different route of entry. These are termed the interlaminar, caudal, and transforaminal approaches. The procedures involve the injection of a solution containing local anesthetic with or without corticosteroids.

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days’ notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.