



MASSACHUSETTS

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Medical Policy

Epidural Steroid Injections for Neck and Back Pain

Table of Contents

- [Policy: Commercial](#)
- [Description](#)
- [Information Pertaining to All Policies](#)
- [Authorization Information](#)
- [Policy History](#)
- [Coding Information](#)
- [References](#)

Policy Number: 690

BCBSA Reference Number: 2.01.94 (For Plan internal use only)

Related Policies

- Artificial Intervertebral Disc: Lumbar Spine, #[592](#)
- Artificial Intervertebral Disc: Cervical Spine, #[585](#)
- 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 neck and 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 at least sixty percent 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.

Epidural steroid injections are considered **INVESTIGATIONAL** when treating the thoracic area of the spine.

The use of fluorography (imaging of the epidural space) as a component of epidural steroid injections is considered **INVESTIGATIONAL**.

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is not required .
Commercial PPO and Indemnity	Prior authorization is not required .

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, and Indemnity:

CPT Codes

CPT codes:	Code Description
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)

HCPCS Codes

HCPCS codes:	Code Description
J0702	Injection, betamethasone acetate 3 mg and betamethasone sodium phosphate 3 mg
J1020	Injection, methylprednisolone acetate, 20 mg
J1030	Injection, methylprednisolone acetate, 40 mg
J1040	Injection, methylprednisolone acetate, 80 mg
J1094	Injection, dexamethasone acetate, 1 mg
J1100	Injection, dexamethasone sodium phosphate, 1 mg
J3301	Injection, triamcinolone acetonide, not otherwise specified, 10 mg

The following ICD Diagnosis Codes are considered medically necessary when submitted with the CPT and HCPCS codes above if medical necessity criteria are met:

ICD-10 Diagnosis Codes

ICD-10-CM Diagnosis codes:	Code Description
M47.22	Other spondylosis with radiculopathy, cervical region
M47.23	Other spondylosis with radiculopathy, cervicothoracic region
M47.25	Other spondylosis with radiculopathy, thoracolumbar region
M47.26	Other spondylosis with radiculopathy, lumbar region
M47.27	Other spondylosis with radiculopathy, lumbosacral region
M50.10	Cervical disc disorder with radiculopathy, unspecified cervical region
M50.11	Cervical disc disorder with radiculopathy, high cervical region
M50.121	Cervical disc disorder at C4-C5 level with radiculopathy
M50.122	Cervical disc disorder at C5-C6 level with radiculopathy
M50.123	Cervical disc disorder at C6-C7 level with radiculopathy
M50.13	Cervical disc disorder with radiculopathy, cervicothoracic region
M51.15	Intervertebral disc disorders with radiculopathy, thoracolumbar region
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M54.12	Radiculopathy, cervical region
M54.13	Radiculopathy, cervicothoracic region
M54.15	Radiculopathy, thoracolumbar region
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M54.30	Sciatica, unspecified side
M54.31	Sciatica, right side
M54.32	Sciatica, left side
M54.40	Lumbago with sciatica, unspecified side
M54.41	Lumbago with sciatica, right side
M54.42	Lumbago with sciatica, left side

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:

CPT Codes

CPT codes:	Code Description
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)
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)

Description

Back Pain

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 a 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, 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 the over-treatment of patients who may not benefit from interventions for back pain.²

Lumbar or Cervical Radiculopathy

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.³ 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

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

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 may reduce swelling of the vertebral disc and/or surrounding structures, leading to pain relief.

Treatment

Regardless of specific etiology, conservative management is the first-line treatment for most patients with neck or 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 Physicians⁴. 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.¹

For patients who fail conservative therapy, a number of interventional therapies are 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.⁵ A number of surgical interventions are available, such as discectomy and spinal fusion, each of which can be performed by a variety of 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 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.⁶ 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.² 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.⁶

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. Others contend that up to 6 injections per year are safe.

Summary

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.

For individuals who have lumbar or cervical radiculopathy who receive ESI, the evidence includes randomized controlled trials (RCTs) and a number of systematic reviews or 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. The 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. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have spinal stenosis who receive ESIs, the evidence includes a moderately large RCT (N=400) and systematic reviews of 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 in the systematic reviews did not report a benefit for ESIs. The evidence is insufficient to determine the effects of technology on health outcomes.

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 the effects of the technology on health outcomes.

Policy History

Date	Action
1/2022	Clarified coding information.
4/2021	Clarified coding information.
1/2021	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
1/2021	Medicare information removed. See MP #132 Medicare Advantage Management for local coverage determination and national coverage determination reference.
12/2020	Epidural steroid injections will not be reimbursed for spinal stenosis and low back pain. Effective 12/1/2020.
12/2019	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
1/2019	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
3/2018	Policy title clarified. 3/8/2018
1/2018	Annual policy review. New references added.
1/2017	Clarified coding information for the 2017 code changes.
1/2016	Annual policy review. New references added.
3/2015	New medical policy describing medically necessary, not medically necessary and investigational indications. Effective 3/1/2015.

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](#)

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