Subject: Epidural Corticosteroid Injections

Medical Policy #: 5.9
Status: Reviewed

Medical Policy

Original Effective Date: 05/17/2010
Last Review Date: 05-26-2021

Disclaimer

Refer to the member's specific benefit plan and Schedule of Benefits to determine coverage. This may not be a benefit on all plans or the plan may have broader or more limited benefits than those listed in this Medical Policy.

Description

Epidural corticosteroid injections are utilized in the treatment of disc-related diseases arising from the spinal nerve roots. Epidural Injections (EIs) can be performed via an interlaminar or caudal approach or a transforaminal approached with or without image guidance and/or local anesthetic. Epidural injections are most effective in those cases where the radicular pain is prominent but neuralgic findings are minimal and conservative therapies (rest, physical therapy and use of anti-inflammatory agents/analgesics) have failed.

The effect of Epidural space injections on pain is not curative, but palliative and repeat injections may be beneficial in the management of patients who have a favorable response to an initial injection.

This policy does not apply to acute pain conditions, such as control of post-surgical pain or obstetrical use during labor and delivery.

Coverage Determination

Prior Authorization is required. Logon to Pres Online to submit a request: https://ds.phs.org/preslogin/index.jsp

PHP follows the Local Coverage Determination (LCD) for Commercial, Medicare and Medicaid based on the following.

I. For Lumbar Epidural Injection: PHP follows Wisconsin Physicians Service, LCD (L36521), with related policy article (A57555), an epidural injections to the lumbar 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 corticosteroids with or without local anesthetic.

For purposes of this policy, a “session” is defined as all epidural or spinal procedures performed on a single calendar day.

Indications:

Services will be considered medically reasonable and necessary only if performed by appropriately trained providers, please see the Provider Qualification section of the LCD.

1. Pain associated with 1 or more of the following:
   - Herpes Zoster
   - Suspected radicular pain, based on radiation of pain along the dermatome (sensory distribution) of a nerve
   - Neurogenic claudication
   - Low back pain, numeric pain rating scale (NPRS) ≥ 3/10 (moderate to severe pain) associated with significant impairment of activities of daily living (ADLs) and one of (a or b):
     a. Substantial imaging abnormalities such as a central disc herniation.
     b. Severe degenerative disc disease or central spinal stenosis.

2. Failure of four weeks (counting from onset of pain) of non-surgical, non-injection care, which may include

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appropriate oral medication(s) and physical therapy/modalities to the extent tolerated.

Exceptions to the 4-week wait may include:
  a. pain from Herpes Zoster
  b. at least moderate pain with significant functional loss at work or home.
  c. severe pain unresponsive to outpatient medical management.
  d. inability to tolerate non-surgical, non-injection care due to co-existing medical condition(s)
  e. prior successful injections for same specific condition with relief of at least 3 months’ duration.

NOTE: See additional requirements by Wisconsin Physicians Service, LCD (L36521), with related policy article (A57555), for requirements on the following:
   • Procedure Requirements such as:
     o Levels per session
     o Frequency - All time intervals are determined on a rolling basis. For example, the limitation of coverage to six sessions in a year refers to a rolling 12-month period. The year begins with the first session and completes one year later. The next rolling year begins with the first session after completion of the preceding rolling year.
   • Provider Qualifications
   • Limitations

Other Related National Coverage Documents (not applicable to epidural injections):
   • NCD 280.14 Infusion Pumps - For external and implantable pumps
   • Local Coverage Determination (LCD): Implantable Infusion Pump (L35112)/(A56778).

II. For Epidural Injections for Pain Management: PHP follows Novitas LCD (L36920), with the related policy article (A56681).

For purposes of this policy, a “session” is defined as all EIs, diagnostic selective nerve root blocks (DSNRBs) or spinal injection procedures performed on a single day.

This LCD imposes frequency limitations. For frequency limitations, please refer to the Utilization Guidelines section of the LCD.

Indications:
Epidural Injections are generally performed to treat pain arising from spinal nerve roots. EIs can be performed via an interlaminar or caudal approach or a transforaminal approach.

An epidural injection is considered medically reasonable and necessary with the following conditions:

Each patient must be thoroughly evaluated by a physician or non-physician practitioner whose license and state scope of practice allow evaluation and treatment outlined in the Provider Qualification section of the LCD. All aspects of the procedure and its related care are within the scope of practice of the provider’s professional licensure.

A central or systemic source of pain or neurologic deficit shall be determined prior to epidural injection. If a central or systemic process is present, but the pain or neurologic deficit is clearly unrelated, injection therapy or EI may still be indicated when at least one of the indications listed below is present.

1. Pain from Herpes Zoster or suspected radicular pain based on radiation of pain along the dermatome of a nerve.
2. Pain from Neurogenic claudication that includes any of the following:
   • Pain severe enough to cause some degree of functional deficit;
   • Failure of at least four weeks of noninvasive care*;
   • Imaging demonstrating a correlative region of nerve/cord impingement.
3. Pain from CervicoThoracic or Lumbar radicular pain with any of the following:
   • Pain severe enough to cause some degree of functional deficit;
   • Failure of at least four weeks of non-invasive care*;
   • Imaging demonstrating a correlative region of nerve impingement.
4. Back pain without lower extremities symptoms and failure of four weeks of non-surgical, non-injection care* with either:
   • documented VAS for pain or NPRS greater than or equal to 3/10 (moderate to severe pain), OR
   • functional impairment in ADLs;
   AND
   • the pain or functional impairment is associated with any of the following:
     o substantial imaging abnormality, such as a central disc herniation or high intensity zone;
     o documented severe degenerative disc disease or central spinal stenosis;
     o discogenic pain, not attributable to facet joint or sacroiliac joint pain.

*It is generally accepted that the majority of back radicular pain will improve with conservative treatment over a four-
week period. All appropriate non-surgical, non-injection treatments which includes appropriate oral medications and physical therapy (to the extent tolerated) should be considered along with a rationale for interventional treatment.

**Exceptions to the four week** non-surgical/non-injection care prior to initiation of epidural injection therapy, should be documented. These may include, but are not limited to one or more of the following:

- Pain from Herpes Zoster;
- Severe pain unresponsive to outpatient medical management;
- Inability to tolerate non-surgical, non-injection care due to co-existing medical conditions(s);
- At least moderate pain with significant functional loss at work or home;
- Prior successful lumbar ESI for same specific condition with relief of at least 3 months’ duration.

**NOTE:** See additional requirements by Novitas LCD (L36920), with the related policy article (A56681) for requirements on the following:

- Procedure Requirements
- Additional Suggested Procedural Requirements/Considerations
- Limitations, please review sessions
- Contraindications to Epidural Injection or Diagnostic Selective Nerve Root Block
- Anesthesia
- Provider Qualifications
- Documentation Requirements
- Utilization Guidelines – Example: A diagnostic selective nerve root block (DSNRB) is considered in the same manner as an Epidural Injection and constitutes one of the two injections allowed in a single session. No more than 3 epidural injection sessions (6 injections, including both diagnostic and therapeutic injections) may be performed in a 6-month period and no more than 6 epidural sessions (12 injections, including both diagnostic and therapeutic injections) may be performed in all anatomic regions in a 12-month period regardless of the number of levels involved.

**Coding**

The coding listed in this medical policy is for reference only. Covered and non-covered codes are within this list.

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>The following CPT codes apply to <strong>Lumbar Epidural Injections</strong>, see related LCA (A57555), for coding guidance and covered diagnosis listing.</th>
</tr>
</thead>
<tbody>
<tr>
<td>62322</td>
<td>Injection(s), of diagnostic or therapeutic substance(s), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, <strong>lumbar or sacral</strong>; without imaging guidance</td>
</tr>
<tr>
<td>62323</td>
<td>Injection(s), of diagnostic or therapeutic substance(s), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, <strong>lumbar or sacral</strong>; without imaging guidance</td>
</tr>
<tr>
<td>62326</td>
<td>Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s), not including neurolytic substances, interlaminar epidural or subarachnoid, <strong>lumbar or sacral</strong>; without imaging guidance</td>
</tr>
<tr>
<td>62327</td>
<td>Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s), not including neurolytic substances, interlaminar epidural or subarachnoid, <strong>lumbar or sacral</strong>; with imaging guidance</td>
</tr>
<tr>
<td>64483</td>
<td>Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT): <strong>lumbar or sacral</strong>, single level</td>
</tr>
<tr>
<td>64484</td>
<td>Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level</td>
</tr>
</tbody>
</table>

**ICD-10 CODE**

For coding guidance and covered diagnosis listing, or the above listed CPT codes, see related LCA (A57555).

<table>
<thead>
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<tr>
<td>62320</td>
<td>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, <strong>cervical or thoracic</strong>; without imaging guidance</td>
</tr>
</tbody>
</table>

Not every Presbyterian health plan contains the same benefits. Please refer to the member’s specific benefit plan and Schedule of Benefits to determine coverage [MPMPPC051001].
<table>
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<th>CPT Codes</th>
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<tr>
<td>62321</td>
<td>Injection(s), of diagnostic or therapeutic substance(s), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, <strong>cervical or thoracic</strong>; with imaging guidance</td>
</tr>
<tr>
<td>62322</td>
<td>Injection(s), of diagnostic or therapeutic substance(s), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, <strong>lumbar or sacral</strong>; without imaging guidance</td>
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<td>Injection(s), of diagnostic or therapeutic substance(s), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, <strong>lumbar or sacral</strong>; with imaging guidance</td>
</tr>
<tr>
<td>62325</td>
<td>Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s), not including neurolytic substances, interlaminar epidural or subarachnoid, <strong>cervical or thoracic</strong>; with imaging guidance</td>
</tr>
<tr>
<td>62326</td>
<td>Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s), not including neurolytic substances, interlaminar epidural or subarachnoid, <strong>lumbar or sacral</strong>; without imaging guidance</td>
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<tr>
<td>62327</td>
<td>Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s), not including neurolytic substances, interlaminar epidural or subarachnoid, <strong>lumbar or sacral</strong>; with imaging guidance</td>
</tr>
<tr>
<td>64479</td>
<td>Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging (fluoroscopy or CT) guidance; <strong>cervical or thoracic</strong>, single level</td>
</tr>
<tr>
<td>64480</td>
<td>Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); <strong>cervical or thoracic</strong>, each additional level</td>
</tr>
<tr>
<td>64483</td>
<td>Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); <strong>lumbar or sacral</strong>, single level</td>
</tr>
<tr>
<td>64484</td>
<td>Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); <strong>lumbar or sacral</strong>, each additional level</td>
</tr>
</tbody>
</table>

**ICD-10 CODE**

For coding guidance and covered diagnosis listing, for the above listed CPT codes, see related LCA (A56681) for LCD L36920

The following CPT codes associated with the services outlined in this policy will not have diagnosis limitations applied at this time: 62320, 62322, 62324, and 62326.

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**Reviewed by / Approval Signatures**

Clinical Quality & Utilization Mgmt. Committee: Norman White MD  
Medical Director: David Yu MD  
Date Approved: 05-26-2021

Reviewed by: New Mexico Ortho Group and Presbyterian Medical Group Ortho.

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**References**

1. CMS, Local Coverage Determination, **Lumbar Epidural Injections (L36521)**, Revision history date 11-01-2019, R#7. [Cited 04/13/2021]
2. CMS, Local Coverage Article, Billing and Coding: Lumbar Epidural Injections (A57555), Effective Date: 11/09/2019, Revision date: 01/01/2021 R1 [Cited 04/13/2021]
3. CMS, Local Coverage Determination by Novitas for Epidural Injections for Pain Management (L36920), Revision history date07/01/2020, R#10. [Cited 04/13/2021].
5. MCG, Health Ambulatory Care, Epidural Corticosteroid Injection (A-0225). Last updated: 03-17-2021. [Cited 04/13/2021]

Not every Presbyterian health plan contains the same benefits. Please refer to the member’s specific benefit plan and Schedule of Benefits to determine coverage [MPMPPC051001].
Publication History

01-29-14: Presbyterian policy retired
01-29-14: Presbyterian now using MCG Criteria A-0225
05-20-20: Annual review: Reviewed by PHP Medical Policy Committee on 05/07/20 and agreed to the following:
  • Replace MCG A-0225 with LCD L36521 (Wisconsin) and L36920 (Novitas) due to MCG only focusing on injection(s) for back pain and CMS expands coverage for other conditions.
  • Policy title changed to remove “Back Pain” from Epidural Corticosteroid Injection for Back Pain.
  • U/S guidance, (CPT 0228T, 0229T, 0230T and 0231T) are not covered.
  • Prior Auth is now required for CPT 62321
05-26-21: Annual review. Reviewed by PHP Medical Policy Committee on 05/07/2021. Continue to follow Lumbar Epidural Injections LCD L36521 (Wisconsin); and/or Epidural Injections for Pain Management L36920 (Novitas). No criteria changes to the LCDs, except for LCD L36920 will now allow (effective for dates of service on and after 07/01/2020), interlaminar and transforaminal epidural injections using ultrasound guidance. They have removed Limitation #1 during this update. Continue PA for 62321, 62322, 62323, 64483, 64484.

This Medical Policy is intended to represent clinical guidelines describing medical appropriateness and is developed to assist Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian) Health Services staff and Presbyterian medical directors in determination of coverage. The Medical Policy is not a treatment guide and should not be used as such. For those instances where a member does not meet the criteria described in these guidelines, additional information supporting medical necessity is welcome and may be utilized by the medical director in reviewing the case. Please note that all Presbyterian Medical Policies are available online at: Click here for Medical Policies

Web links:
At any time during your visit to this policy and find the source material web links has been updated, retired or superseded, PHP is not responsible for the continued viability of websites listed in this policy.

When PHP follows a particular guideline such as LCDs, NCDs, MCG, NCCN etc., for the purposes of determining coverage; it is expected providers maintain or have access to appropriate documentation when requested to support coverage. See the References section to view the source materials used to develop this resource document.

Not every Presbyterian health plan contains the same benefits. Please refer to the member’s specific benefit plan and Schedule of Benefits to determine coverage [MPMPPC051001].