Clinical Policy: Caudal or Interlaminar Epidural Steroid Injections

Reference Number: CP.MP.164 Coding Implications
Date of Last Revision: 06/24 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Epidural steroid injections have been used for pain control in patients with radiculopathy, spinal stenosis, and nonspecific low back pain, despite inconsistent results as well as heterogeneous populations and interventions in randomized trials. Epidural injections are performed utilizing three approaches in the lumbar spine: caudal, interlaminar, and transforaminal. Generally, candidates for epidural steroid injection are individuals who have acute radicular symptoms or neurogenic claudication unresponsive to traditional analgesics and rest, with significant impairment in activities of daily living.

Note: For guidelines for transforaminal ESIs, reference *CP.MP.165 Selective Nerve Root Blocks and Transforaminal Epidural Steroid Injections.*

Policy/Criteria
It is the policy of health plans affiliated with Centene Corporation® that invasive pain management procedures performed by a physician are **medically necessary** when *the relevant criteria are met, only one procedure is performed per visit, with imaging guidance (except in rare instances, with documented justification), and the member/enrollee is not currently being treated with full anticoagulation therapy. If on warfarin, international normalized ratio (INR) should be ≤ 1.4 prior to the procedure.* Discontinuing anti-platelet therapy is a clinical decision balancing risks and benefits of the procedure on therapy, versus the underlying medical condition if not treated appropriately.[23]

I. It is the policy of health plans affiliated with Centene Corporation® that caudal or interlaminar epidural steroid injections (ESIs) are **medically necessary** for the following indications:

A. *One caudal or interlaminar ESI for acute pain* management (pain lasting < three months) when all of the following are met:
1. There is severe radicular pain that interferes substantially with activities of daily living (ADLs);
2. Severe pain persists after treatment with nonsteroidal anti-inflammatory drugs (NSAID) and/or opiates (both ≥ three days or contraindicated/not tolerated);
3. The member/enrollee cannot tolerate chiropractic or physical therapy and the injection is intended as a bridge to therapy.

B. *Initial ESI for chronic pain,* all of the following:
1. Request is for one caudal or interlaminar ESI at one level in the cervical, thoracic or lumbar region;
2. Persistent radicular pain has been caused by spinal stenosis, disc herniation or degenerative changes in the vertebrae, as confirmed by physical exam and imaging;
3. Pain interferes with ADLs and has lasted for at least three months;

4. The member/enrollee has failed to respond to conservative therapy including all of the following:
   a. ≥ four weeks chiropractic, physical therapy or prescribed home exercise program;
   b. NSAID ≥ three weeks or NSAID contraindicated or not tolerated;
   c. ≥ four weeks activity modification.

C. *Second caudal or interlaminar ESI for chronic pain* that **did not** improve from the first ESI, all of the following:
1. Request is for an ESI at one level in the cervical, thoracic or lumbar region;
2. At least two weeks have passed since the first ESI.

D. *Subsequent caudal or interlaminar ESI for recurrence of chronic* pain that **had improved** from the first or second ESI, all of the following:
1. Initial injection(s) led to ≥ 50% relief and functional improvement for at least two months;
2. At least two months have passed since the last ESI;
3. Less than four injections have been administered within 12 months;
4. Less than 12 months have elapsed since the initial injection at the level requested.

II. It is the policy of health plans affiliated with Centene Corporation that *a third or subsequent caudal or interlaminar ESI for chronic pain* that **did not** improve from the first two ESIs is considered **not medically necessary** because effectiveness has not been established.

III. It is the policy of health plans affiliated with Centene Corporation that *continuation of injections* beyond 12 months or more than four therapeutic injections is considered **not medically necessary** because effectiveness and safety have not been established. When more definitive therapies cannot be tolerated or provided, consideration will be made on a case by case basis.

IV. It is the policy of health plans affiliated with Centene Corporation that *caudal or interlaminar ESI for any other indication or location* is considered **not medically necessary** because effectiveness has not been established.

Background

There is much debate on the efficacy and medical necessity of multiple interventions for managing spinal pain. Epidural glucocorticoid injections have been used for pain control in patients with radiculopathy, spinal stenosis, and nonspecific low back pain despite inconsistent results as well as heterogeneous populations and interventions in randomized controlled trials (RCTs). Epidural injections are performed utilizing three approaches in the lumbar spine: caudal, interlaminar, and transforaminal.[2] Generally, candidates for epidural steroid injection are individuals who have acute radicular symptoms or neurogenic claudication unresponsive to traditional analgesics and rest, with significant impairment in activities of daily living. Epidural steroid injections have been used in the treatment of spinal stenosis for many years, and no validated long-term outcomes have been reported to substantiate their use. However, significant improvement in pain scores have been reported at three months after injection.

Zhai et al conducted a meta-analysis to assess the effects of various surgical and nonsurgical modalities, including epidural injections, used to treat lumbar disc herniation (LDH) or radiculitis. A systemic literature review identified RCTs that compared the use of local anesthetic with and without steroids. The outcomes included pain relief, functional improvement, opioid intake, and therapeutic procedural characteristics. The reviewers concluded the meta-analysis confirms that epidural injections of local anesthetic with or without steroids have beneficial but similar effects in the treatment of patients with chronic low back and lower extremity pain.[1]

Results of a two year follow-up of three randomized, double-blind, controlled trials, with a total of 360 patients with chronic persistent pain of disc herniation receiving either caudal, lumbar interlaminar or transforaminal epidural injections, showed similar efficacy of the three techniques with local anesthetic alone or local anesthetic with steroid.[2] Caudal and interlaminar trials used in the assessment showed some superiority of steroids over local anesthetic at three and six month follow-up. Interlaminar with steroids were superior to transforaminal at 12 months.[2]

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2023, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT Codes	Description
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 (i.e., 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 (i.e., fluoroscopy or CT)
62324	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic,

CPT Codes	Description
	antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
62325	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, cervical or thoracic; with imaging guidance (i.e., 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, 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 (i.e., fluoroscopy or CT)

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Caudal and interlaminar ESI criteria reviewed in CP.MP.118	04/18	04/18
In section D regarding second or subsequent ESI for chronic pain that improved from the diagnostic injections, changed requirement for 3 months having passed from the previous injection to 2 months. Anticoagulation indication moved to policy/criteria section as it is applicable to all injections in this policy.	08/19	08/19
References reviewed and updated	06/20	07/20
In policy statement, changed “with or without radiographic guidance” to “with imaging, (except in rare instances, with documented justification).” Added, “Request is not for cervical interlaminar ESI above C7” to B.5, C.3 and D.5. Changed “review date” in the header to “date of last revision” and “date” in the revision log header to “revision date.” References reviewed and updated. Replaced “member” with “member/enrollee” in all instances. Specialist review.	07/21	07/21
Removed “Request is not for cervical interlaminar ESI above C7” from B.5, C.3 and D.5.	09/21	09/21
Annual review. Note added regarding guidelines for transforaminal ESIs. Background updated with no impact on criteria. References reviewed and updated.	07/22	07/22
Annual review. ICD-10 diagnosis code table removed. References reviewed and updated. Reviewed by external specialist.	07/23	07/23
Annual review. Updated week requirement criteria I.B.4.a.-c. Coding reviewed. References reviewed and updated.	06/24	06/24

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage

decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of member/enrollees. This clinical policy is not intended to recommend treatment for member/enrollees. Member/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid member/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare member/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.