

**BSC\_NIA\_CG\_300 Epidural Spine Injections**

<b>Original Policy Date:</b>	January 1, 2017	<b>Effective Date:</b>	January 1, 2024
<b>Section:</b>	2.0 Medicine	<b>Page:</b>	Page 1 of 14

**Policy Statement**

**Note:** Any injection performed at least two years from prior injections in the same region will be considered a new episode of care and the INITIAL injection requirements must be met for approval. Events such as surgery on the same spinal region or any new pathology would also prompt a new episode of care.

**INDICATIONS FOR EPIDURAL SPINE INJECTIONS OR SELECTIVE NERVE BLOCKS  
(Caudal, Interlaminar, Transforaminal)**

**For the treatment of acute pain or exacerbation of chronic radicular pain<sup>1</sup> ALL of the following must be met:**

- Neck or back pain with acute radicular symptoms<sup>2</sup>
- Pain causing functional disability or average pain level of  $\geq 6$  on a scale of 0 to 10<sup>2-5</sup>
- Duration of pain < 3 months
- Failure to respond to non-operative conservative therapy targeting the requested spinal region for a minimum of 2 weeks unless the medical reason this treatment cannot be done is clearly documented (active therapy components not required)<sup>2, 3</sup>

**For the treatment of spinal stenosis causing axial or radicular pain<sup>1</sup> ALL of the following must be met:**

- Pain causing functional disability or average pain level of  $\geq 6$  on a scale of 0 to 10<sup>2-5</sup>
- Failure to respond to non-operative conservative therapy\* targeting the requested spinal region for a minimum of 6 weeks in the last 6 months unless the medical reason this treatment cannot be done is clearly documented; OR details of engagement in ongoing non-operative conservative therapy\* if the individual has had prior spinal injections in the same region<sup>2, 3</sup>

**For the treatment of failed back surgery syndrome or epidural fibrosis causing axial<sup>6, 7</sup> or radicular pain<sup>1</sup> ALL of the following must be met:**

- Pain causing functional disability or average pain level of  $\geq 6$  on a scale of 0 to 10<sup>2-5</sup>
- Documentation of a medical reason that clearly indicates why an injection is needed (not typically done immediately post-surgery)<sup>5</sup>
- Failure to respond to non-operative conservative therapy\* targeting the requested spinal region for a minimum of 6 weeks in the last 6 months unless the medical reason this treatment cannot be done is clearly documented; OR details of engagement in ongoing non-operative conservative therapy\* if the individual has had prior spinal injections in the same region<sup>2, 3</sup>

**For a diagnostic transforaminal injection to identify the pain generator for surgical planning ALL of the following must be met:**

- Pain causing functional disability or average pain level of  $\geq 6$  on a scale of 0 to 10<sup>2-5</sup>
- Documentation of a pre-operative evaluation and plan for surgery

**NOTE:** No more than 2 levels of transforaminal blocks should be done in one day.<sup>8</sup>

## INDICATIONS FOR REPEAT INJECTIONS

Epidural injections may be repeated only as medically necessary. **Each** epidural injection requires an authorization, and the following criteria must be met for repeat injections:

- Up to 3 epidural injections may be performed in the initial treatment phase, no sooner than 2 weeks apart, provided that at least 30% pain relief or significant documented functional improvement is obtained<sup>5</sup>
- If an injection during the initial treatment phase is unsuccessful, another injection may be performed at a different level in the **same spinal region** or with a change in technique given there is a question about the pain generator or evidence of multi-level pathology
- Epidural injections may only be repeated after the initial treatment phase if the individual has had at least 50% pain relief or significant documented functional improvement for a **minimum of 2 months** after each therapeutic injection<sup>3</sup>
- The individual continues to have pain causing functional disability or average pain level  $\geq 6$  on a scale of 0 to 10<sup>2,3,5</sup>
- The individual is engaged in ongoing active conservative therapy\*, unless the medical reason this treatment cannot be done is clearly documented<sup>2,9</sup>
- In the first year of treatment, a total of 6 epidural injections may be performed **per spinal region** (this includes a series of 3 injections in the initial treatment phase and 3 additional therapeutic injections).<sup>3</sup>
- After the first year of treatment, a maximum of 4 epidural injections may be performed in a 12-month period **per spinal region**.<sup>3,5</sup> If special circumstances are documented (e.g., elderly individual with severe spinal stenosis and not an operative candidate), then repeat injections are limited to a maximum of 6 epidural injections in a 12-month period per spinal region.<sup>5</sup>
- If different spinal regions are being treated, injections should be administered at intervals of no sooner than 7 days unless a medical reason is provided to necessitate injecting multiple regions on the same date of service (see NOTE).<sup>5</sup>

**NOTE:** It is generally considered **not medically necessary** to perform multiple interventional pain procedures on the same date of service. Documentation of a medical reason to perform injections in different regions on the same day can be provided and will be considered on a case-by-case basis (e.g., holding anticoagulation therapy on two separate dates creates undue risk for the patient). Different types of injections in the same spinal region (cervical, thoracic, or lumbar) should not be done on the same day with the exception of a facet injection and ESI performed during the same session for a synovial cyst confirmed on imaging.

## EXCLUSIONS

These requests are excluded from consideration under this guideline:

- Intrathecal injections for pain or spasticity prior to permanent pump insertion
- Implantation of intrathecal catheters or ports for chemotherapy
- Post-operative pain control
- Caudal or spinal anesthesia for surgery

## CONTRAINDICATIONS FOR EPIDURAL INJECTIONS

- Active systemic or spinal infection
- Skin infection at the site of needle puncture
- Severe spinal stenosis resulting in intraspinal obstruction

**NOTE:** Refer to [Appendix A](#) to see the policy statement changes (if any) from the previous version.

## Policy Guidelines

**\*Conservative Therapy** - Non-operative treatment should include a multimodality approach consisting of a combination of active and inactive components. Inactive components can include rest, ice, heat, modified activities, medical devices, acupuncture, stimulators, medications, injections, and diathermy. Active modalities should be region-specific (targeting the cervical, thoracic, or lumbar spine) and consist of physical therapy, a physician-supervised home exercise program\*\*, or chiropractic care.<sup>2, 9, 24</sup>

**\*\*Home Exercise Program (HEP)** - The following **two elements are required** to meet guidelines for completion of conservative therapy:

- Documentation of an exercise prescription/plan provided by a physician, physical therapist, or chiropractor<sup>9, 25, 26</sup>; **AND**
- Follow-up documentation regarding completion of HEP after the required 6-week timeframe or inability to complete HEP due to a documented medical reason (i.e., increased pain or inability to physically perform exercises). Closure of medical offices, closure of therapy offices, patient inconvenience, or noncompliance without explanation does not constitute "inability to complete" HEP.<sup>2, 9</sup>

**Terminology** - Interlaminar Epidural; Selective Nerve Root Injection (transforaminal only); Transforaminal Injection; Injections of Spinal Canal

**CPT Codes:**

**Cervical Thoracic Region:**

- 62320, 62321, 64479 (+64480)

**Lumbar Sacral Region:**

- 62322, 62323, 64483 (+64484)

### GENERAL INFORMATION

It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.

## Description

**Therapeutic Spinal Epidural Injections or Select Nerve Root Blocks (Transforaminal)** are types of interventional pain management procedures. The therapeutic use of epidural injections is for short-term pain relief associated with acute back pain or exacerbation of chronic back pain. With therapeutic injections, a corticosteroid is injected close to the target area with the goal of pain reduction. Epidural injections should be used in combination with other active conservative treatment\* modalities and not as stand-alone treatment for long-term back pain relief. Different approaches used when administering spinal epidural injections<sup>13</sup> include:

- **Interlaminar** epidural injections, with steroids, access the epidural space between two vertebrae (Interlaminar) to treat cervical, lumbar, or thoracic pain with radicular pain.<sup>14</sup> These procedures should be performed using fluoroscopic guidance.<sup>15, 16</sup> Interlaminar epidural injections are the most common type of epidural injection.
- **Transforaminal** epidural injections (also called selective nerve root blocks) access the epidural space via the intervertebral foramen where the spinal nerves exit (cervical, lumbar/sacral, or thoracic region). It is used both diagnostically and therapeutically. Some

studies report lack of evidence and risks of transforaminal epidural injections.<sup>17</sup> These procedures are always aided with fluoroscopic guidance.<sup>1, 16, 18-21</sup>

- **Caudal** epidural injections, with steroids, are used to treat back and lower extremity pain, accessing the epidural space through the sacral hiatus, providing access to the lower nerve roots of the spine. These procedures should be performed using fluoroscopic guidance. Failed back surgery syndrome is the most common reason for the caudal approach.<sup>3, 16, 21-23</sup>

## Related Policies

- N/A

## Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

## Regulatory Status

- N/A

## Rationale

The rationale for the use of spinal epidural injections is that the sources of spinal pain, e.g., discs and joints, are accessible and amendable to neural blockade.

Medical necessity management for epidural injections includes an initial evaluation including history and physical examination as well as a psychosocial and functional assessment. The following must be determined: nature of the suspected organic problem; non-responsiveness to active conservative treatment\*; level of pain and functional disability; conditions which may be contraindications to epidural injections; and responsiveness to prior interventions.

Interventional pain management specialists do not agree on how to diagnose and manage spinal pain; there is a lack of consensus with regards to the type and frequency of spinal interventional techniques for treatment of spinal pain. The American Society of Interventional Pain Physicians (ASIPP) guidelines recommend an algorithmic approach which provides a step- by-step procedure for managing chronic spinal pain based upon evidence-based guidelines.<sup>1, 3</sup> This approach is based on the structural basis of spinal pain and incorporates acceptable evidence of diagnostic and therapeutic interventional techniques available in managing chronic spinal pain.

The guidelines and algorithmic approach referred to above include the evaluation of evidence for diagnostic and therapeutic procedures in managing chronic spinal pain and recommendations for managing spinal pain. The Indications and Contraindications presented within this document are based on the guidelines and algorithmic approach. Prior to performing this procedure, shared decision-making between patient and physician must occur, and the patient must understand the

procedure and its potential risks and results (moderate short-term benefits, and lack of long-term benefits).

### Additional Information

**Hip-spine syndrome**<sup>27-29</sup> - Hip-spine syndrome is a condition that includes both debilitating hip osteoarthritis and low back pain. Abnormal spinal sagittal alignment and difficulty in maintaining proper balance, as well as a wobbling gait, may be caused by severe osteoarthritis of the hip joint. Epidural injections are used to determine a primary pain generator in this condition.

**Spondylolisthesis and nerve root irritation**<sup>13, 30-33</sup> - Degenerative lumbar spondylolisthesis is the displacement of a vertebra in the lower part of the spine; one lumbar vertebra slips forward on another with an intact neural arch and begins to press on nerves. The most common cause, in adults, is degenerative disease; although, it may also result from bone diseases and fractures. Degenerative spondylolisthesis is not always symptomatic. Epidural injections may be used to determine a previously undocumented nerve root irritation because of spondylolisthesis.

**Lumbar spinal stenosis with radiculitis**<sup>13, 34, 35</sup> - Spinal stenosis is narrowing of either the spinal column or of the neural foramina where spinal nerves leave the spinal column, causing pressure on the spinal cord. The most common cause is degenerative changes in the lumbar spine. Neurogenic claudication is the most common symptom, with leg symptoms including the buttock, groin, and anterior thigh; however, symptoms may also radiate down along the posterior leg to the foot. In addition to pain, leg symptoms can include fatigue, heaviness, weakness, or paresthesia. Some individuals may also suffer from accompanying back pain. Symptoms are worse when standing or walking and are relieved by sitting. Lumbar spinal stenosis is often a disabling condition, and it is the most common reason for lumbar spinal surgery in adults over 65 years. The most common levels of stenosis are L3 through L5, but it may occur at multilevel in some individuals. Radiculitis is the inflammation of a spinal nerve root that causes pain to radiate along the nerve paths. Epidural injections help to ascertain the level of the pain generator in this condition.

**Lumbar herniated disc**<sup>36-39</sup> - Epidural steroid injections have been proven to be effective at reducing symptoms of lumbar herniated discs. Observation and epidural steroid injection are effective nonsurgical treatments for this condition.

**Postoperative epidural fibrosis**<sup>40-42</sup> - Epidural fibrosis is a common cause of failed back surgery syndrome. With the removal of a disc, the mechanical reason for pain may be removed, but an inflammatory condition may continue after the surgery and may cause pain. Epidural corticosteroids, with their anti-inflammatory properties, are used to treat postoperative fibrosis and may be used along with oral Gabapentin to reduce pain.

**Failed back surgery syndrome (FBSS)**<sup>21, 43</sup> - Failed back surgery syndrome is characterized by persistent or recurring low back pain, with or without sciatica, following lumbar surgery. The most common cause of FBSS is epidural fibrosis triggered by a surgical procedure such as discectomy. The inflammation resulting from the surgical procedure may start the process of fibrosis and cause pain. Epidural steroid injections are administered to reduce pain.

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## Documentation for Clinical Review

### Please provide the following documentation:

- History and physical and/or consultation notes including:
  - Conservative treatment(s), duration, and patient response
  - Diagnostic evaluation
  - Functional limitation(s)
- Prior procedure(s) and response (if applicable)
- Radiology report(s)
- Electrodiagnostic studies (if applicable)

### Post Service (in addition to the above, please include the following):

- Procedure report(s)

## Coding

*This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy.*

*The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.*

Type	Code	Description
CPT®	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



Type	Code	Description
		epidural or subarachnoid, cervical or thoracic; without imaging guidance
	62321	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; with imaging guidance (i.e., fluoroscopy or CT)
	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
	62323	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); with imaging guidance (i.e., fluoroscopy or CT)
	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	None	

## Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
01/01/2017	Adoption of National Imaging Associates (NIA) Clinical Guidelines
07/01/2018	NIA Clinical Guideline update
07/01/2019	NIA Clinical Guideline update
07/01/2020	Annual NIA clinical guideline update
01/01/2021	Coding update
03/01/2021	Annual NIA clinical guideline update. Policy title changed from Spinal Epidural Injections to current one.
01/01/2022	Annual NIA clinical guideline update.
01/01/2023	Annual NIA clinical guideline update.
01/01/2024	Annual NIA clinical guideline update.

## Definitions of Decision Determinations

**Medically Necessary:** Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

**Investigational/Experimental:** A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

## Prior Authorization Requirements and Feedback (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at [www.blueshieldca.com/provider](http://www.blueshieldca.com/provider).

We are interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration.

For utilization and medical policy feedback, please send comments to: [MedPolicy@blueshieldca.com](mailto:MedPolicy@blueshieldca.com)

*Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.*

**Appendix A**

POLICY STATEMENT	
BEFORE <span style="color: red;">Red font: Verbiage removed</span>	AFTER <span style="color: blue;">Blue font: Verbiage Changes/Additions</span>
<p><b>Epidural Spine Injections BSC_NIA_CG_300</b></p> <p><b>Policy Statement:</b>  <b>Note:</b> Any injection performed at least two years from prior injections in the same region will be considered a new episode of care and the <b>INITIAL</b> injection requirements must be met for approval. Events such as surgery on the same spinal region or any new pathology would also prompt a new episode of care.</p> <p><b>INDICATIONS FOR EPIDURAL SPINE INJECTIONS OR SELECTIVE NERVE BLOCKS</b>                      (Caudal, Interlaminar, Transforaminal)</p> <p><b>For the treatment of acute pain or exacerbation of chronic radicular pain<sup>1</sup> <u>ALL</u> of the following must be met:</b></p> <ul style="list-style-type: none"> <li>• Neck <span style="color: red;">of</span> back pain with acute radicular symptoms<sup>2</sup></li> <li>• Pain causing functional disability or average pain levels <span style="color: red;">s</span> of <math>\geq 6</math> on a scale of 0 to 10 <sup>2-5</sup></li> <li>• Duration of pain &lt; 3 months</li> <li>• Failure to respond to non-operative conservative therapy targeting the requested spinal region for a minimum of 2 weeks unless the medical reason this treatment cannot be done is clearly documented (active therapy components not required)<sup>2,3</sup></li> </ul> <p><b>For the treatment of spinal stenosis causing axial or radicular pain<sup>1</sup> <u>ALL</u> of the following must be met:</b></p> <ul style="list-style-type: none"> <li>• Pain <span style="color: red;">causing</span> functional disability or average pain levels <span style="color: red;">s</span> of <math>\geq 6</math> on a scale of 0 to 10 <span style="color: blue;">2-5</span></li> <li>• Failure to respond to non-operative conservative therapy* targeting the requested spinal region for a minimum of 6 weeks in the last 6 months unless the medical reason this treatment cannot be done is clearly documented; OR details of engagement in</li> </ul>	<p><b>Epidural Spine Injections BSC_NIA_CG_300</b></p> <p><b>Policy Statement:</b>  <b>Note:</b> Any injection performed at least two years from prior injections in the same region will be considered a new episode of care and the INITIAL injection requirements must be met for approval. Events such as surgery on the same spinal region or any new pathology would also prompt a new episode of care.</p> <p><b>INDICATIONS FOR EPIDURAL SPINE INJECTIONS OR SELECTIVE NERVE BLOCKS</b>                      (Caudal, Interlaminar, Transforaminal)</p> <p><b>For the treatment of acute pain or exacerbation of chronic radicular pain<sup>1</sup> <u>ALL</u> of the following must be met:</b></p> <ul style="list-style-type: none"> <li>• Neck <span style="color: blue;">or</span> back pain with acute radicular symptoms<sup>2</sup></li> <li>• Pain causing functional disability or average pain level of <math>\geq 6</math> on a scale of 0 to 10 <sup>2-5</sup></li> <li>• Duration of pain &lt; 3 months</li> <li>• Failure to respond to non-operative conservative therapy targeting the requested spinal region for a minimum of 2 weeks unless the medical reason this treatment cannot be done is clearly documented (active therapy components not required)<sup>2,3</sup></li> </ul> <p><b>For the treatment of spinal stenosis causing axial or radicular pain<sup>1</sup> <u>ALL</u> of the following must be met:</b></p> <ul style="list-style-type: none"> <li>• Pain causing functional disability or average pain level of <math>\geq 6</math> on a scale of 0 to 10 <sup>2-5</sup></li> <li>• Failure to respond to non-operative conservative therapy* targeting the requested spinal region for a minimum of 6 weeks in the last 6 months unless the medical reason this treatment cannot be done is clearly documented; OR details of engagement in</li> </ul>

**POLICY STATEMENT**

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<p>ongoing non-operative conservative therapy* if the individual has had prior spinal injections in the same region<sup>2, 3</sup></p> <p><b>For the treatment of failed back surgery syndrome or epidural fibrosis causing radicular pain<sup>1</sup> ALL of the following must be met:</b></p> <ul style="list-style-type: none"> <li>• Pain causing functional disability or average pain levels of <math>\geq 6</math> on a scale of 0 to 10 <sup>2-5</sup></li> <li>• Documentation of a medical reason that clearly indicates why an injection is needed (not typically done immediately post-surgery)<sup>3</sup></li> <li>• Failure to respond to non-operative conservative therapy* targeting the requested spinal region for a minimum of 6 weeks in the last 6 months unless the medical reason this treatment cannot be done is clearly documented; OR details of engagement in ongoing non-operative conservative therapy* if the individual has had prior spinal injections in the same region<sup>2, 3</sup></li> </ul> <p><b>For a diagnostic transforaminal injection to identify the pain generator for surgical planning ALL of the following must be met:</b></p> <ul style="list-style-type: none"> <li>• Pain causing functional disability or average pain levels of <math>\geq 6</math> on a scale of 0 to 10 <sup>2-5</sup></li> <li>• Documentation of a pre-operative evaluation and plan for surgery</li> </ul> <p><b>NOTE:</b> No more than 2 levels of transforaminal blocks should be done in one day.<sup>6</sup></p> <p><b>FREQUENCY OF REPEAT INJECTIONS</b></p> <p>Epidural injections may be repeated only as medically necessary. <b>Each</b> epidural injection requires an authorization, and the following criteria must be met for repeat injections:</p> <ul style="list-style-type: none"> <li>• Up to 3 epidural injections may be performed in the initial treatment phase, no sooner than 2 weeks apart, provided that at least 30% pain relief or significant documented functional improvement is obtained<sup>5</sup></li> <li>• If the first injection is unsuccessful, a <b>second</b> injection may be performed at a different <b>spinal</b> level or with a change in technique</li> </ul>	<p>ongoing non-operative conservative therapy* if the individual has had prior spinal injections in the same region<sup>2, 3</sup></p> <p><b>For the treatment of failed back surgery syndrome or epidural fibrosis causing axial<sup>6,7</sup> or radicular pain<sup>1</sup> ALL of the following must be met:</b></p> <ul style="list-style-type: none"> <li>• Pain causing functional disability or average pain level of <math>\geq 6</math> on a scale of 0 to 10 <sup>2-5</sup></li> <li>• Documentation of a medical reason that clearly indicates why an injection is needed (not typically done immediately post-surgery)<sup>3</sup></li> <li>• Failure to respond to non-operative conservative therapy* targeting the requested spinal region for a minimum of 6 weeks in the last 6 months unless the medical reason this treatment cannot be done is clearly documented; OR details of engagement in ongoing non-operative conservative therapy* if the individual has had prior spinal injections in the same region<sup>2, 3</sup></li> </ul> <p><b>For a diagnostic transforaminal injection to identify the pain generator for surgical planning ALL of the following must be met:</b></p> <ul style="list-style-type: none"> <li>• Pain causing functional disability or average pain level of <math>\geq 6</math> on a scale of 0 to 10 <sup>2-5</sup></li> <li>• Documentation of a pre-operative evaluation and plan for surgery</li> </ul> <p><b>NOTE:</b> No more than 2 levels of transforaminal blocks should be done in one day.<sup>8</sup></p> <p><b>INDICATIONS FOR REPEAT INJECTIONS</b></p> <p>Epidural injections may be repeated only as medically necessary. <b>Each</b> epidural injection requires an authorization, and the following criteria must be met for repeat injections:</p> <ul style="list-style-type: none"> <li>• Up to 3 epidural injections may be performed in the initial treatment phase, no sooner than 2 weeks apart, provided that at least 30% pain relief or significant documented functional improvement is obtained<sup>5</sup></li> <li>• If an injection <b>during the initial treatment phase</b> is unsuccessful, <b>another</b> injection may be performed at a different level <b>in the same spinal region</b> or with a change in technique given there is a</li> </ul>

POLICY STATEMENT

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<p>given there is a question about the pain generator or evidence of multi-level pathology</p> <ul style="list-style-type: none"> <li>• Epidural injections may only be repeated after the initial treatment phase if <b>symptoms return, and</b> the individual has had at least 50% pain relief or significant documented functional improvement for a <b>minimum of 2 months</b> after each therapeutic injection<sup>3</sup></li> <li>• The individual continues to have pain causing functional disability or average pain levels <math>\geq 6</math> on a scale of 0 to 10 <sup>2,3,5</sup></li> <li>• The individual is engaged in ongoing active conservative therapy*, unless the medical reason this treatment cannot be done is clearly documented<sup>2,7</sup></li> <li>• In the first year of treatment, a total of 6 epidural injections may be performed per spinal region (this includes a series of 3 injections in the initial phase and 3 additional therapeutic injections).<sup>3</sup></li> <li>• <b>Repeat therapeutic injections should not be done more frequently than every 2 months with</b> a maximum of 4 epidural injections in a 12-month period per spinal region.<sup>3,5</sup> If special circumstances are documented (e.g., elderly individual with severe spinal stenosis and not an operative candidate) then repeat injections are limited to a maximum of 6 epidural injections in a 12-month period per spinal region.<sup>5</sup></li> <li>• If different spinal regions are being treated, injections should be administered at intervals of no sooner than 7 days unless a medical reason is provided to necessitate injecting multiple regions on the same date of service (see NOTE).<sup>3</sup></li> </ul> <p><b>NOTE:</b> It is generally considered <b>not medically necessary</b> to perform multiple interventional pain procedures on the same date of service. Documentation of a medical reason to perform injections in different regions on the same day can be provided and will be considered on a case-by-case basis (i.e., holding anticoagulation therapy on two separate dates creates undue risk for the patient). Different types of injections in the same spinal region (cervical, thoracic, or lumbar) should not be done on the same day with the exception of a facet injection and ESI performed <b>in</b> the same session for a synovial cyst.</p>	<p>question about the pain generator or evidence of multi-level pathology</p> <ul style="list-style-type: none"> <li>• Epidural injections may only be repeated after the initial treatment phase if the individual has had at least 50% pain relief or significant documented functional improvement for a <b>minimum of 2 months</b> after each therapeutic injection<sup>3</sup></li> <li>• The individual continues to have pain causing functional disability or average pain level <math>\geq 6</math> on a scale of 0 to 10 <sup>2,3,5</sup></li> <li>• The individual is engaged in ongoing active conservative therapy*, unless the medical reason this treatment cannot be done is clearly documented<sup>2,9</sup></li> <li>• In the first year of treatment, a total of 6 epidural injections may be performed <b>per spinal region</b> (this includes a series of 3 injections in the initial <b>treatment</b> phase and 3 additional therapeutic injections).<sup>3</sup></li> <li>• <b>After the first year of treatment,</b> a maximum of 4 epidural injections <b>may be performed</b> in a 12-month period <b>per spinal region</b>.<sup>3,5</sup> If special circumstances are documented (e.g., elderly individual with severe spinal stenosis and not an operative candidate), then repeat injections are limited to a maximum of 6 epidural injections in a 12-month period per spinal region.<sup>5</sup></li> <li>• If different spinal regions are being treated, injections should be administered at intervals of no sooner than 7 days unless a medical reason is provided to necessitate injecting multiple regions on the same date of service (see NOTE).<sup>3</sup></li> </ul> <p><b>NOTE:</b> It is generally considered <b>not medically necessary</b> to perform multiple interventional pain procedures on the same date of service. Documentation of a medical reason to perform injections in different regions on the same day can be provided and will be considered on a case-by-case basis (e.g., holding anticoagulation therapy on two separate dates creates undue risk for the patient). Different types of injections in the same spinal region (cervical, thoracic, or lumbar) should not be done on the same day with the exception of a facet injection and ESI performed <b>during</b> the same session for a synovial cyst <b>confirmed on imaging</b>.</p>

**POLICY STATEMENT**

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<p><b>EXCLUSIONS</b> These requests are excluded from consideration under this guideline:</p> <ul style="list-style-type: none"> <li>• Intrathecal injections for pain or spasticity prior to permanent pump insertion</li> <li>• Implantation of intrathecal catheters or ports for chemotherapy</li> <li>• Post-operative pain control</li> <li>• Caudal or spinal anesthesia for surgery</li> </ul> <p><b>CONTRAINDICATIONS FOR EPIDURAL INJECTIONS</b></p> <ul style="list-style-type: none"> <li>• Active systemic or spinal infection</li> <li>• Skin infection at the site of needle puncture</li> <li>• Severe spinal stenosis resulting in intraspinal obstruction</li> </ul>	<p><b>EXCLUSIONS</b> These requests are excluded from consideration under this guideline:</p> <ul style="list-style-type: none"> <li>• Intrathecal injections for pain or spasticity prior to permanent pump insertion</li> <li>• Implantation of intrathecal catheters or ports for chemotherapy</li> <li>• Post-operative pain control</li> <li>• Caudal or spinal anesthesia for surgery</li> </ul> <p><b>CONTRAINDICATIONS FOR EPIDURAL INJECTIONS</b></p> <ul style="list-style-type: none"> <li>• Active systemic or spinal infection</li> <li>• Skin infection at the site of needle puncture</li> <li>• Severe spinal stenosis resulting in intraspinal obstruction</li> </ul>