INSTRUCTIONS FOR USE

This Medical Policy provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee's document (e.g., Certificate of Coverage (COC) or Summary Plan Description (SPD)) may differ greatly. In the event of a conflict, the enrollee's specific benefit document supersedes this Medical Policy. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this Medical Policy. Other Policies and Coverage Determination Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the Milliman Care Guidelines®, to assist us in administering health benefits. The Milliman Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

COVERAGE RATIONALE

The use of ultrasound guidance for facet joint injection(s) and epidural steroid injection(s) is unproven. There is insufficient clinical evidence regarding its safety and/or efficacy in published peer-reviewed medical literature. The available published evidence for ultrasound guidance for facet and epidural injections is limited to a small feasibility study and a cadaver study.

Facet Joint Injections
Diagnostic facet joint injection and/or facet nerve block (e.g., medial branch block) is proven to localize the source of pain to the facet joint in persons with spinal pain.
Therapeutic facet joint injection is unproven for the treatment of chronic spinal pain. Clinical evidence about the very existence of facet joint syndrome is conflicting, and evidence from studies is inadequate regarding the superiority of periodic facet joint injections compared to placebo in relieving chronic spinal pain.

Epidural Steroid Injections
Epidural steroid injection is proven for the treatment of acute and sub-acute sciatica or radicular pain of the low back caused by spinal stenosis, disc herniation or degenerative changes in the vertebrae.

Epidural steroid injection is unproven for all other indications of the lumbar spine. There is a lack of evidence from randomized controlled trials indicating that epidural steroid injections effectively treat patients with lumbar pain not associated with sciatica or radicular pain.

Note: This policy does not apply to obstetrical epidural anesthesia utilized during labor and delivery.

Additional Information
Facet joint injection, as a diagnostic procedure prior to radiofrequency ablation, is not recommended in patients with:
- neurologic abnormalities
- more than one pain syndrome
- definitive clinical and/or imaging findings pointing to a specific diagnosis other than facet joint syndrome
- previous spinal surgery at the clinically suspected levels

BACKGROUND

Pain in the lower back or low back pain is a common concern, affecting up to 90% of Americans at some point in their lifetime. The vast majority of episodes are mild and self-limited. Up to 50% of affected persons will have more than one episode. Low back pain is not a specific disease; rather it is a symptom that may occur from a variety of different processes. Management of back pain that is persistent and disabling despite the use of recommended conservative treatment is challenging. Epidural steroid injections, and facet joint injections and blocks have been employed in the treatment of back pain, as an alternative to more invasive interventions. (Chou et al., 2009).

Facet blocks can be considered a diagnostic or therapeutic procedure. Facet blocks using short-acting local anesthetics can be used to diagnose facet (zygapophyseal) joint syndrome as the cause of chronic back pain. Facet blocks utilizing long acting local anesthetics, anti-inflammatory agents such as corticosteroids, or nerve ablating techniques such as radiofrequency lesioning have been investigated for treatment of chronic back pain attributed to facet joint syndrome. (Hayes, 2007)

Epidural steroid injection (ESI) is a nonsurgical treatment for managing low back pain and sciatica caused by disc herniation or degenerative changes in the vertebrae. The goal of ESI is to relieve pain, improve function, and reduce the need for surgical intervention. (Hayes, 2007)
Chronic nonmalignant back pain is defined as pain lasting 3 - 6 months or more that is not due to cancer.

**CLINICAL EVIDENCE**

**Ultrasound Guidance**
Galiano et al. (2007) compared ultrasound guided facet joint injections with CT-controlled interventions in a prospective randomized clinical trial. Forty adult patients with chronic low back pain were evenly assigned either to an ultrasound or CT group. The primary outcomes were accuracy and time to final needle placement. Of the patients randomized to ultrasound, 18 were judged to be feasible for an ultrasound approach. In 16 of these patients, the facet joints were clearly visible. In the 2 patients not judged to be feasible for the ultrasound approach, CT placement was performed due to inability to visualize the facet joint. For the ultrasound group, the space to be injected was identified within 5mm of the joint space. All of the needle placements were confirmed by CT. The duration of procedure and radiation dose was 14.3 +/- 6.6 minutes and 14.2 +/- 11.7 mGy.cm in the ultrasound group, and 22.3 +/- 6.3 minutes and 364.4 +/- 213.7 mGy.cm in the CT group. Both groups showed an effect from facet joint injections, demonstrating accurate needle placement. No difference between groups was detected. The authors concluded that the ultrasound approach to the facet joints is feasible and has minimal risk in the large majority of patients and results in a significant time and radiation dose reduction. The study is limited by small sample size. In addition, if the depth of the facet joint is greater the 8cm, visualization is not feasible with ultrasound. CT guidance is reliable and straightforward in 100% of patients regardless of their physical constitution. The fact that CT requires multiple imaging slices accounts for the increase in radiation exposure.

Another study by Galiano et al. (2005) was limited to cadaver studies.

**Facet Injections**
Use of diagnostic blocks with injection of local anesthesia into the facet joints or around the medial branch nerves to identify the possible sources of spinal pain appears to be an established diagnostic procedure. However, there is no gold standard for the diagnosis of facet syndrome against which the accuracy of diagnostic facet blocks can be assessed. Single blocks have been compared to what are regarded as diagnostically more valid double blocks using local anesthetic agents with different pharmacologic properties and durations of action. With double blocks, a short- and a long-acting anesthetic are used, preferably administered in a double-blind, random order on separate occasions. In a positive response, pain relief occurs with both but lasts longer with the long-acting anesthetic. Compared to a single-blind, double block, Schwarzer et al. (1994) found that a single lumbar facet joint diagnostic block had a 38% false-positive rate.

A systematic review by Boswell et al. (2007) evaluated the effectiveness of 3 types of facet joint interventions (intra-articular injections, medial branch nerve blocks, and neurotomy) in managing chronic spinal pain. The primary outcome measure was pain relief. For intra-articular facet joint injections and medial branch blocks, short-term pain relief was defined as relief lasting less than 6 weeks and long-term relief as 6 weeks or longer. For medial branch blocks, repeated injections at defined intervals provided long-term pain relief. For medial branch radiofrequency neurotomy, short-term pain relief was defined as relief lasting less than 3 months and long-term relief as lasting 3 months or longer. Other outcome measures included functional improvement, improvement of psychological status, and return to work. The authors concluded that for intra-articular facet joint injections, the evidence for short- and long-term pain relief is limited for cervical pain and moderate for lumbar pain. For medial branch blocks, the evidence is moderate for short- and long-term pain relief. For medial branch neurotomy, the evidence is moderate for short- and long-term pain relief. The evidence for thoracic medial branch neurotomy is indeterminate.

Injections with local anesthetics and/or corticosteroids into or around facet joints of the spine have not been validated as a treatment for facet joint syndrome pain. Although some uncontrolled
studies have reported a wide range of pain relief from facet joint injections, controlled studies evaluating this treatment modality found that injection of local anesthetic and/or corticosteroids had little value in relieving pain in patients with chronic back pain. Lilius et al. (1989), in a randomized controlled trial that included patients with low back pain for over 3 months, compared bupivacaine and methylprednisolone acetate injected into 2 facet joints (n=28), the same mixture injected around 2 facet joints (n=39), and saline injected into 2 facet joints (n=42). No differences were found between the groups in return to work, pain relief, or on clinical examination. This was a reasonably well-designed trial except that the sample sizes were relatively small and the method of randomization was not described.

Manchicanti et al. (2010a) conducted a double-blind randomized controlled trial of facet joint nerve blocks to manage chronic low back pain. One hundred twenty patients were equally randomized to receive either a local anesthetic only (group I) or a local anesthetic mixed with a steroid (group II). Outcomes were measured at baseline, 3, 6, 12, 18 and 24 months post-treatment with the Numeric Rating Scale (NRS), the Oswestry Disability Index 2.0 (ODI), work status, and opioid intake. Significant pain relief (≥ 50%) and functional improvement of ≥ 40% were observed in 85% in Group 1, and 90% in Group II, at 2-year follow-up. The authors found that both groups had equal relief with or without the addition of steroids to the treatment.

Carette et al. (1991) conducted a well-designed, randomized controlled trial that included patients with low back pain of at least 6 months duration. Patients were assigned to receive either facet joint injection with methylprednisolone acetate (n=49) or saline (n=48). At 1 and 3 months after the injections, the 2 groups did not differ on measures of pain relief, functional status, or back flexion. At 6 months, those who received corticosteroid injections reported more improvement, less pain, and less physical disability, but this might have been explained in part by more use of other concurrent interventions.

Jackson (1992) randomized patients with pain for a mean of 3.5 months (range, 1 to 12 months) to lumbar facet joint injection with either lidocaine (n=12) or saline (n=13) and found no differential effect on pain scores. The major weakness of this trial was that its sample size was too small.

Revel et al. (1998) conducted a randomized study of 80 patients with low back pain to receive facet injections of lidocaine or saline. The investigators indicated that lidocaine gave greater pain relief than saline.

Very few relevant new studies on facet joint injection were identified that were published after 2000. Most of the articles published since those times have been review articles or uncontrolled case series. Nelemans et al. (2001) systematically reviewed the Medline and Embase databases for randomized controlled trials evaluating the effectiveness of injection therapy in patients with low back pain. Their search criteria captured articles published prior to 1998 and included 21 randomized trials. They concluded that evidence and long-term outcome data is lacking to support the efficacy of injections therapy for chronic low back pain.

Mayer et al. (2004) conducted a randomized controlled trial to investigate the use of facet injections as an adjunct to lumbar exercises in 70 patients with lumbar segmental rigidity. Patients were assigned to facet injections and exercise (n=36) or exercise alone (n=34). A higher proportion of injection patients (87-95%) displayed range of motion improvement compared to the exercise only patients (64-79%). No significant differences in self-reported pain or disability were found between the 2 groups.

A study by Shih et al. (2005) was conducted to investigate the diagnostic and clinical value of lumbar facet joint injections in 277 patients with low back pain. Good response was demonstrated in 72.1% of patients after 3 weeks, 40.7% of patients after 6 weeks, and 31.4% of patients after 12 weeks.

In a study conducted by Manchikanti et al. (2004), 100 consecutive patients with facet joint neck
pain received cervical facet joint nerve blocks. Ninety-two percent of patients had pain relief at 3 months, 82% had pain relief at 6 months, and 56% had pain relief at 12 months compared to baseline measurements.

Manchikanti (2006) also investigated 55 consecutive patients with thoracic facet joint pain treated with medial branch blocks. Significant pain relief was achieved in 71% of patients at 3 and 6 months, 71% at 24 months, and 69% at 36 months. The investigators concluded that thoracic medial branch blocks were an effective treatment for managing thoracic facet joint pain.

In a prospective, randomized, double-blind trial by Manchikanti et al. (2007), data from a total of 60 patients were included, with 15 patients in each of 4 groups. Thirty patients were in a non-steroid group consisting of Groups I (control, with lumbar facet joint nerve blocks using bupivacaine) and II (with lumbar facet joint nerve blocks using bupivacaine and Sarapin); another 30 patients were in a steroid group consisting of Groups III (with lumbar facet joint nerve blocks using bupivacaine and steroids) and IV (with lumbar facet joint nerve blocks using bupivacaine, Sarapin, and steroids). Significant improvement in pain and functional status were observed at 3 months, 6 months, and 12 months, compared to baseline measurements. The average number of treatments for 1 year was 3.7 with no significant differences among the groups. Duration of average pain relief with each procedure was 14.8 +/- 7.9 weeks in the non-steroid group and 12.5 +/- 3.3 weeks in the steroid group, with no significant differences among the groups. Therapeutic lumbar facet joint nerve blocks with local anesthetic, with or without Sarapin or steroids, may be effective in the treatment of chronic low back pain of facet joint origin.

In addition to transient local pain at the injection sites, risks involved with facet joint injections include potential infection, hemorrhage, neurologic damage, and chemical meningitis as well as x-ray exposure from fluoroscopy.

Facet joint injections incur the general risks of bleeding, infection, local tissue damage, allergic reaction, or adverse drug effects. If needles are improperly placed, there is the possibility of intravascular injection, subarachnoid spread, and spinal anesthesia. Improper placement with percutaneous radiofrequency facet denervation risks dysesthetic pain, radicular pain, or neurologic damage. (Dreyer et al., 1997)

**Professional Societies**

**American College of Radiology (ACR):** Current recommendations from the ACR regarding diagnosis of causes of chronic back pain state that facet injection is useful for patients with multilevel disease diagnosed by any imaging modality to identify the specific level(s) producing symptoms. (Daffner, 2005)

**American Society of Interventional Pain Physicians (ASIPP):** Evidence-Based Practice Guidelines in the Management of Chronic Spinal Pain state that during the diagnostic phase, a patient may receive 2 injections at intervals of no sooner than one week or preferably 2 weeks. In the therapeutic phase (after the diagnostic phase is completed), the suggested frequency would be 2-3 months or longer between injections, provided that ≥ 50% relief is obtained for 8 weeks. For medial branch neurotomy, the suggested frequency would be 6 months or longer (maximum of 2 times per year) between each procedure, provided that 50% or greater relief is obtained for 10 to 12 weeks. (Manchikanti et al., 2009)

**Epidural Steroid Injections**

Novak and Nemeth (2008) conducted a literature review to evaluate the effect of repeat epidural injections and/or the timing of injections to treat low back pain. Of the 91 articles identified, 15 were included in the review. The authors found little evidence to suggest that repeat epidural steroid injections are beneficial. The authors also found little evidence to suggest guidelines for frequency and timing of epidural steroid injections. The authors suggest that further studies with at least a 1 year follow-up are necessary to evaluate the timing and number of repeat injections.
Abdi et al. (2007) conducted a systemic review of published trials and abstracts of scientific meetings, published between January 1966 and October 2006, to determine the efficacy and safety of ESIs. The primary outcome measure was pain relief. Other outcome measures were functional improvement, improvement of psychological status, and return to work. They identified 11 randomized trials of lumbar interlaminar ESI. Of these studies, 8 had favorable results for short-term (< 6 weeks) relief and 1 was positive for long-term (6 weeks) relief. The level of evidence for interlaminar ESIs was considered strong for short-term pain relief and limited for long-term pain relief. There were 7 randomized trials of lumbar transforaminal ESI (TFESI), 5 of which had favorable results for both short- and long-term pain relief. The level of evidence for TFESI was considered strong for short-term pain relief and moderate for long-term pain relief. Of the 8 randomized trials of caudal ESIs, 5 had favorable results for short-term pain relief and 4 had favorable results for long-term pain relief. The level of evidence for caudal epidural injections was considered strong for short-term relief and moderate for long-term relief.

Manchicanti et al. (2010b) conducted a double-blind randomized controlled trial of interlaminar epidural steroid injections, with and without steroids, in managing chronic pain of lumbar disc herniation or radiculitis. Seventy patients were equally randomized to receive either a local anesthetic only (group I) or a local anesthetic mixed with a steroid (group II). Outcomes were measured at baseline, 3, 6, and 12 months post-treatment with the Numeric Rating Scale (NRS), the Oswestry Disability Index 2.0 (ODI), employment status, and opioid intake. Significant pain relief (≥ 50%) was seen at 12 months in 74% of patients in group I and 86% in group II, and 69% and 83% in ODI scores respectively. Patients in group II also had more improvement in functional status at 12 months (83% vs. 69%) and required less opioid intake.

Karppinen et al. (2001) conducted a double-blind, randomized controlled trial of methylprednisolone plus bupivacaine for the treatment of sciatica. Patients received an epidural injection of either saline (n=80) or steroid (n=80). At 2 weeks postinjection, the steroid group had significantly greater improvement in leg pain, straight leg raising, lumbar flexion and more patient satisfaction than the saline group. The saline group had significantly reduced back pain at the 3-month and 6-month follow-ups and significantly reduced leg pain at 6 months. One year postinjection, there were no differences between groups.

Valat et al. (2003) conducted a multicenter, double-blind, randomized controlled study of prednisolone for hospitalized patients with sciatica. The 85 patients in the study were treated with 3 epidural injections at 2-day intervals of either prednisolone (n=43) or saline (n=42). The patients were evaluated at 5 days, 20 days, and 35 days postinjection, and there were no significant differences between groups for any outcome measures. The results suggested that epidural prednisolone had no effect on sciatica. However, because only hospitalized patients were included in the study, patients selected for this study may have had more serious disease than those in the general population with sciatica.

A total of 206 patients with a diagnosis of "postlaminectomy syndrome" were enrolled in Aldrete's (2003) randomized, blinded, comparative study of indomethacin or methylprednisolone. The results of the study suggested that epidural injection of indomethacin and methylprednisolone were equally effective at reducing back pain.

Buttermann (2004) conducted a randomized comparative study of epidural betamethasone injections or discectomy for the treatment of herniated nucleus pulposus. Initially the patients were treated with either epidural injections of betamethasone (n=50) or discectomy (n=50). Patients who failed to obtain relief with steroid injections were entered into a crossover group (n=27) and treated with discectomy. The discectomy group had earlier motor recovery than the steroid group; however, there were no other significant differences between groups. The results suggested that epidural betamethasone injections were not as effective as discectomy. However, steroid injections were effective for up to 3 years in nearly half of the patients who had not responded to conservative treatment.
Khot et al. (2004) performed a single-blind, randomized, placebo-controlled study of epidural steroid injection for patients with low back pain of discogenic origin. In this study, 60 patients were randomly assigned to receive epidural methylprednisolone, while 60 patients received a placebo epidural injection. After 1 year, there was no difference in outcome between the treatment and placebo groups.

Wilson-MacDonald et al. (2005) conducted a double-blind, randomized controlled study of methylprednisolone plus local anesthetic for the treatment of nerve root compression. Patients received either an epidural (n=44) or intramuscular (n=48) injection of methylprednisolone plus bupivacaine. To maintain patient blinding, the initial injection technique was the same for both groups. After the needle made contact with the lamina of the vertebra, it was withdrawn and redirected for the intramuscular injection or advanced into the epidural space. Thirty-five days after the injection, the epidural group had significantly less pain than the control group. The proportion of patients who eventually had surgery was the same in each group. The results suggested that the effects of epidural steroid injections were only short lived.

In one of the largest recent double-blind, randomized studies, Price et al. (2005) evaluated the effect of epidural steroid injection on 228 patients with either acute or chronic sciatica. Patients received either epidural steroid or placebo injection, up to 3 injections, and were then evaluated periodically for a 12-month period. At 3 weeks after injection, more patients in the steroid group reported reduction in pain and showed improvement in the Oswestry Disability Index score than did patients in the placebo group; however, at all other follow-up times, there were no significant differences in any outcomes between the treatment and control group. This suggested that any effect of epidural steroid was transient.

Cyteval et al. (2006) prospectively followed 229 patients with lumbar radiculopathy (herniated disc and degenerative lesions) at 2 weeks and 1 year after percutaneous periradicular (transforaminal) steroid infiltration. The aim of the study was to find predictive factors of efficacy of the steroid injection procedure. ESIs were performed under fluoroscopic guidance, and periradicular flow was confirmed with contrast medium. Short- and long-term pain relief was demonstrated. The only predictive factor of pain relief was symptom duration before the procedure. The authors concluded that periradicular (transforaminal) infiltration was a simple, safe, and effective (short- and long-term relief) nonsurgical procedure with an improved benefit when performed early in the course of the illness. The primary limitation of the study was the lack of a control group.

Complications associated with epidural injections include steroid side effects, dural puncture, transient increased pain, transient paresthesias, aseptic and/or bacterial meningitis, neurological dysfunction or damage, epidural abscess, intracranial air, allergic reaction, epidural hematoma, persistent dural leak, nausea, headache, paraplegia, tetraplegia, seizure, stroke, and death. (Derby, 2004; Everett, 2004)

Epidural steroid injections should not be performed at the site of congenital anatomic anomalies or in persons who have had previous surgery in which the epidural space is absent, altered, or eliminated. The treatment is contraindicated in patients with systemic infections or bleeding tendencies; infection at the injection site; patients undergoing active anticoagulation therapy; patients at risk for medical decompensation from fluid retention, such as those with severe congestive heart failure or poorly controlled hypertension; and patients with other unstable medical conditions. Steroid injections may lower resistance to infection and should be used with caution in patients with poorly controlled diabetes, since the corticosteroid injection may transiently increase the blood glucose levels. In addition, fluoroscopy should not be used to guide epidural injections for pregnant women to avoid radiation exposure of the fetus. (McLain, 2005)

Professional Societies

American Society of Anesthesiologists (ASA): As of 2010, the ASA has not issued a statement specifically on the use of epidural steroids for the management of low back pain and/or
sciatica. However, the ASA Task Force on Pain Management issued more general practice guidelines for chronic pain management. The 2010 ASA guidelines recommended that: Epidural steroid injections with or without local anesthetics may be used as part of a multimodal treatment regimen to provide pain relief in selected patients with radicular pain or radiculopathy. Transforaminal epidural injections should be performed with appropriate image guidance to confirm correct needle position and spread of contrast before injecting a therapeutic substance.

**American Academy of Neurology (AAN):** In 2007, the Therapeutics and Technology Assessment Subcommittee of the AAN released an assessment addressing the use of epidural steroid injections (ESIs) to treat radicular lumbosacral pain. The Subcommittee concluded that there was some evidence that, when compared with control treatments, ESIs may result in some improvement in radicular lumbosacral pain when assessed between 2 and 6 weeks following the injection. However, they noted that the average magnitude of effect is small and, in general, ESIs for radicular lumbosacral pain does not impact average impairment of function, need for surgery, or provide long-term pain relief beyond 3 months. Therefore, the routine use of ESIs for radicular lumbosacral pain was not recommended. The Subcommittee did not make any recommendation for the use of ESIs to treat radicular cervical pain due to the paucity of evidence for this indication. (Armon, 2007)

**American Society of Interventional Pain Physicians (ASIPP):** Evidence-Based Practice Guidelines in the Management of Chronic Spinal Pain state that there is no consensus among interventional pain management specialists regarding the type, dosage, frequency, total number of injections, or other interventions. The frequency and total number of injections have been considered important issues, although controversial and poorly addressed. The authors recommend that administration be based solely on patient response, safety profile of the drug, experience of the patient, and pharmacological and chemical properties, such as duration of action and suppression of adrenals. (Manchicanti, et al., 2009)

ASIPP also recommends that the suggested frequency of epidural injections should be 2 months or longer between each injection provided that at least 50% relief is obtained for 6 to 8 weeks. Injections should be limited to a maximum of 4 to 6 times per year. (Manchicanti, et al., 2009)

**American Association of Neurological Surgeons and the Congress of Neurological Surgeon:** A guideline from the American Association of Neurological Surgeons and the Congress of Neurological Surgeons states that there is no evidence in the clinical literature supporting the long-term benefit of epidural injections or facet joint injections. (Resnick, 2005)

**North American Spine Society (NASS):** The NASS has developed clinical guidelines that address the diagnosis and treatment of degenerative lumbar spinal stenosis (NASS, 2007). The guidelines state that while there is evidence that nonfluoroscopically guided interlaminar and single radiographically guided transforaminal ESIs can result in short-term symptom relief in patients with neurogenic claudication or radiculopathy, there is conflicting evidence concerning long-term efficacy. The guidelines also note that there is some evidence that a multiple injection regimen of radiographically guided transforaminal ESIs or caudal injections can produce long-term relief of pain in patients with radiculopathy or neurogenic intermittent claudication from lumbar spinal stenosis. However, the evidence is of relatively poor quality, and therefore no strong recommendation in support of this therapy was made.

**U.S. FOOD AND DRUG ADMINISTRATION (FDA)**

The two most common local anesthetics used for facet joint pain treatment, lidocaine and bupivacaine, are not specifically indicated for facet joint blockade. Instead, the indications for
these drugs are more general. The indications for local anesthetics include production of local and regional anesthesia or analgesia for diagnostic and therapeutic procedures.

There are a number of injectable steroid formulations approved by the FDA, but none are specifically approved for epidural injection.


**CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)**

Medicare does not have a National Coverage Determination (NCD) for specific types of injections for pain such as epidural and facet injections for spinal pain.

Local Coverage Determinations (LCD) which address injections for pain exist and compliance with these policies is required where applicable. See LCDs for:

- Epidural and Transforaminal Epidural Injections
- Epidural Injections
- Epidural
- Facet Joint Injections
- Paravertebral facet Joint Block
- Transforaminal, Epidural, Paravertebral Facet and Sacroiliac Joint Injections

Accessed November 8, 2011

**APPLICABLE CODES**

The codes listed in this policy are for reference purposes only. Listing of a service or device code in this policy does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the benefit document. This list of codes may not be all inclusive.

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<th>CPT® Code (Unproven)</th>
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### CPT® Code (Facet)

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### Proven ICD-9 Code (Facet)

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<td>053.14</td>
<td>Herpes zoster myelitis</td>
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<td>Other herpes zoster with nervous system complications</td>
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<td>Unspecified reflex sympathetic dystrophy</td>
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<td>Reflex sympathetic dystrophy of other specified site</td>
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<td>Multiple sclerosis</td>
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<td>353.1</td>
<td>Lumbosacral plexus lesions</td>
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<td>Lumbosacral root lesions, not elsewhere classified</td>
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<td>353.8</td>
<td>Other nerve root and plexus disorders</td>
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<td>355.0</td>
<td>Lesion of sciatic nerve</td>
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<td>355.9</td>
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<td>721.2</td>
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<td>721.3</td>
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<td>722.10</td>
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<td>722.81</td>
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<td>722.82</td>
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<td>722.51</td>
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<td>Degeneration of lumbar or lumbosacral intervertebral disc</td>
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<td>722.73</td>
<td>Intervertebral lumbar disc disorder with myelopathy, lumbar region</td>
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722.83 Postlaminectomy syndrome, lumbar region
724.02 Spinal stenosis, lumbar region, without neurogenic claudication
724.03 Spinal stenosis, lumbar region, with neurogenic claudication
724.09 Spinal Stenosis, other than cervical, other
724.3 Sciatica
724.4 Thoracic or lumbosacral neuritis or radiculitis, unspecified
724.6 Disorders of sacrum
738.4 Acquired spondylolisthesis
805.4 Closed fracture of lumbar vertebra without mention of spinal cord injury
953.1 Injury to dorsal nerve root
953.2 Injury to lumbar nerve root
953.3 Injury to sacral nerve root
956.0 Injury to sciatic nerve

REFERENCES


Epidural Steroid and Facet Injections for Spinal Pain: Medical Policy (Effective 04/01/2012)


**POLICY HISTORY/REVISION INFORMATION**

<table>
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<th>Date</th>
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| 04/01/2012 | • No change to coverage rationale  
• Updated list of applicable (proven) ICD-9 diagnosis codes; added 355.0  
• Archived previous policy version 2012T0004P |