

MEDICAL POLICY

POLICY TITLE	EPIDURAL STEROID INJECTIONS FOR BACK PAIN AND FACET NERVE BLOCKS
POLICY NUMBER	MP 4.014

CLINICAL BENEFIT	<input type="checkbox"/> MINIMIZE SAFETY RISK OR CONCERN. <input checked="" type="checkbox"/> MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. <input type="checkbox"/> ASSURE APPROPRIATE LEVEL OF CARE. <input type="checkbox"/> ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. <input checked="" type="checkbox"/> ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. <input type="checkbox"/> ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
Effective Date:	6/1/2025

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I. POLICY

NOTE: Documentation of the usage of validated patient focused pain intensity assessment scales (such as Numeric Rating Scales, Visual Analog Scales, Verbal Rating Scales, the *Faces Pain Scale*, or the *Pain Thermometer*) is considered **medically necessary** when determining different levels of pain sensation during medical management.

Facet Joint Injections/Medial Branch Blocks

Initial Diagnostic Facet Joint Injection/Medial Branch Block

Facet joint injections/medial branch blocks may be considered **medically necessary** for lumbar or cervical pain lasting more than 3 months, despite appropriate conservative treatment, as a diagnostic procedure to determine whether the pain is of facet joint origin.

Second Diagnostic Facet Joint Injection/Medial Branch Block

A second diagnostic facet joint injection/medial branch block may be considered **medically necessary** when all the following criteria are met:

- The initial diagnostic injection was successful at relieving pain (see policy guidelines); AND
- The second diagnostic injection will be administered at the same level(s) as the initial diagnostic block; AND
- Radiofrequency joint denervation is being considered.

Therapeutic Facet Joint Injection/Medial Branch Block

Therapeutic facet joint injections/medial branch blocks may be considered **medically necessary** when all the following criteria are met:

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- There is documented successful response with 2 sequential diagnostic facet joint injections/medial branch blocks at the same level(s); AND
- The individual is not a candidate for radiofrequency joint denervation; AND
- For subsequent therapeutic blocks there was a successful response to the prior therapeutic injection for at least 3 months duration; AND
- For each spinal region, a maximum of 4 therapeutic facet joint sessions are medically necessary in a 12-month period.

Facet joint injection/medial branch block, diagnostic or therapeutic, for any indication other than the ones listed above is considered **investigational**. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

Ultrasound guidance for facet joint injections is considered **investigational**. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

Epidural Steroid Injections

Epidural steroid injections performed with fluoroscopic guidance may be considered **medically necessary** for the treatment of neck or back pain when the following criteria are met:

- Lumbar radiculopathy (sciatica) or cervical radiculopathy that is not responsive to at least 4 weeks of conservative management (see Policy Guidelines section); and
- Persistent pain is present of at least moderate-to-severe intensity; and
- Short-term relief of pain is the anticipated outcome.

Repeat treatment of persistent pain due to radiculopathy or sciatica may be considered **medically necessary** under the following conditions:

- Previous epidural steroid injections were successful at relieving pain; and
- At least 30 days have elapsed since the prior injection (see Policy Guidelines section for maximum number of injections); and
- No more than 6 injections were given over a 12-month period.

Repeat treatment is considered **investigational** in the absence of documentation of benefit from epidural steroid injections. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

Simultaneous treatment of 2 vertebral levels may be considered **investigational** if the criteria above are met at each level. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

Simultaneous treatment of more than 2 vertebral levels is considered **investigational**. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

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Epidural steroid injections are considered **investigational** in all other situations, including but not limited to treatment of spinal stenosis and nonspecific low back pain. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

The use of fluorography (imaging of the epidural space) as a component of epidural steroid injections is considered **investigational**. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

POLICY GUIDELINES

Facet Joint Injections/Medial Branch Blocks

Conservative therapies may include medications (e.g., non-steroidal anti-inflammatory drugs, antidepressants), physical treatments (exercise, heat or cold therapy, massage, physical therapy), integrative treatments (acupuncture, spinal manipulation if indicated) and others (nutrition, weight loss, sleep hygiene).

A successful block refers to a sustained meaningful reduction in pain. This is subjective but often defined as a 20-point improvement on a 0-to-100 visual analog scale or a 50% improvement using a validated scale.

Epidural Steroid Injections

The diagnosis of lumbar radiculopathy is typically made by a combination of suggestive signs and symptoms in conjunction with imaging that demonstrates compression of a spinal nerve root. Symptoms are due to irritation of the spinal nerve root at L4, L5, or S1, and may include posterior leg pain that extends past the knee, a loss of sensation in a dermatomal pattern, and/or loss of deep tendon reflexes. However, all of these symptoms may not be present. On exam, provocative tests such as the straight leg maneuver are positive. Magnetic resonance imaging is the most useful imaging modality and can confirm or exclude the presence of nerve root compression, most commonly due to herniated disc.

There are several aspects of epidural steroid injection therapy that are not standardized. Expert opinion was sought through clinical vetting on the following issues:

- The optimal time for assessing a response to epidural steroid injections. Expert opinion supports that response can be assessed anytime from immediately to several weeks after the procedure, with the most popular time to assess response being 1 to 2 weeks after injection.
- The definition of a clinically significant response to injections. Expert opinion supports that a reasonable definition of response is at least a 20-point improvement on a 0-to-100 visual analog scale, or an improvement of at least 50% in functional status, when measured using a validated scale.
- The maximum number of injections in 1 year. There is no agreement on the maximum number of injections that should be given in 1 year. Some experts agree that no more than 3 injections should be given in 1 year, but other experts believe that more than 3 per

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year can be used safely. None of the expert opinions supported more than 6 injections given over a 12-month period.

Conservative nonsurgical therapy for at least 4 weeks should include the following:

- Use of prescription-strength analgesics for several weeks at a dose sufficient to induce a therapeutic response.
 - Analgesics should include anti-inflammatory medications with or without adjunctive medications such as nerve membrane stabilizers or muscle relaxants AND
- Participation in at least 4 weeks of physical therapy (including active exercise) or documentation of why the individual could not tolerate physical therapy, AND
- Evaluation and appropriate management of associated cognitive and behavioral issues

Cross-References:

MP 2.072 Trigger Point and Tender Point Injections

MP 4.041 Dry Needling of Myofascial Trigger Points

MP 5.048 Diagnosis and Treatment of Sacroiliac Joint Pain

MP 5.049 Facet Joint Denervation

II. PRODUCT VARIATIONS

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This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations as discussed in Section VI. Please see additional information below.

FEP PPO: Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at:

<https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies>

III. DESCRIPTION/BACKGROUND

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Back Pain

Back pain is an extremely common condition. Most episodes are self-limited and will resolve within 1 month, but a small percentage will persist and become chronic. Patients with chronic back pain may suffer from serious disability and may use a high volume of medical services. Despite high utilization, many patients with chronic back pain do not improve with available treatments, including surgical interventions. Therefore, there is a high unmet need to determine the efficacy of different treatments for chronic back pain and to determine which patient populations may benefit from specific interventions. In addition, there has been a proliferation of new technologies, combined with large increases in the number of patients treated and in the intensity of treatment. Therefore, there is a concern for overtreatment of patients who may not benefit from interventions for back pain.

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Lumbar or Cervical Radiculopathy

Back pain can result from a variety of underlying causes. Radiculopathy is a subset of back pain that is associated with irritation of 1 or more spinal nerve roots. Symptoms of lumbar radiculopathy, which is sometimes known as sciatica, include pain that radiates down the leg to below the knee, numbness, muscle weakness, and lack of reflexes in a dermatomal distribution. Most patients with radiculopathy respond to conservative care with a resolution of their symptoms within several weeks to several months following onset. In a subset of patients, symptoms and signs of progressive muscle weakness prompt a more aggressive intervention to prevent permanent dysfunction. In other patients, symptoms persist despite conservative management, without progression of neurologic signs, and further treatment options are sought for pain relief.

Spinal Stenosis

Spinal stenosis is another common source of back pain. Spinal stenosis is caused by narrowing of the spinal canal due to degenerative changes, leading to impingement of the spinal cord and the spinal nerve roots. Symptoms of spinal stenosis can include back pain, leg pain with exertion (neurogenic claudication), muscle weakness, and sensory deficits. Definitive treatment for spinal stenosis is surgery, which includes decompression of the spinal canal with or without spinal fusion. Epidural steroids may reduce inflammation from pressure on the spinal cord and thus reduce symptoms of compression.

Nonspecific Low Back Pain

Nonspecific low back pain, sometimes called mechanical low back pain, is diagnosed when no specific etiology of pain can be identified. Although the etiology of nonspecific low back pain is uncertain, many experts feel that the pain is of discogenic origin or due to painful movement of the vertebrae. In these instances, epidural steroid injections may reduce swelling of the vertebral disc and/or surrounding structures, leading to pain relief.

Treatment

Regardless of specific etiology, conservative management is the first-line treatment for most patients with neck or back pain. Nonsteroidal anti-inflammatory drugs or other analgesics are used for symptom relief. These agents should be used for at least several weeks at a dose sufficient to induce a therapeutic response. Additionally, modification of activity in conjunction with some form of exercise therapy is frequently prescribed early in the course of symptoms and typically involves a physical therapist. For patients with persistent non-radicular back pain, current guidelines recommend interdisciplinary rehabilitation, which is defined as an integrated approach using physical rehabilitation in conjunction with a psychological or psychosocial intervention.

For patients who fail conservative therapy, a number of interventional therapies are available, which range from minimally invasive procedures, such as injections, to major surgeries, such as spinal decompression with fusion. Injections can be given in different locations (e.g., soft tissues, intraspinal, sacroiliac joints) and can use different therapeutic agents (e.g., botulinum toxin, steroids, proteolytic enzymes). Other interventional techniques include radiofrequency ablation,

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prolotherapy, and chemonucleolysis. Most of these nonsurgical interventions do not have high-quality evidence demonstrating their efficacy. A number of surgical interventions are available, such as discectomy and spinal fusion, each of which can be performed by a variety of techniques. The decision to undertake surgery is best made in the setting of shared decision making between the patient and surgeon, with thorough consideration given to the risks and benefits of surgery.

Epidural Steroid Injections

Epidural injection therapy is one of several therapies available for patients who fail conservative treatment and is one of the most common modalities used in this group of patients. Epidural steroid injections are performed by inserting a needle into the space between the dura and ligamentum flavum and injecting a steroid preparation. There is considerable variability in the technical aspects of epidural injections. Several different approaches may be used for entering the epidural space (translaminar, transforaminal, caudal). In addition, epidural steroid injections may be administered with or without fluoroscopic guidance. Some investigators have estimated that lack of correct needle position in the epidural space may occur in 25% or more of injections administered. Variability of the technique may also involve factors such as the depth of injection into the epidural space, the volume of injectate, and the filling patterns of the injectate.

Treatment is generally given as 1 to 3 injections, each performed at least 1 month apart. Some experts recommend no more than 3 injections in a 12-month period, owing to concerns about the adverse events of chronic steroid administration, both locally and systemically. Others contend that up to 6 injections per year are safe.

Regulatory Status

Steroids are not approved by the U.S. Food and Drug Administration for use as epidural injections; such use represents an off-label administration of a U.S. Food and Drug Administration-approved medication. The specific preparations used for epidural injections are steroids added to a sterile saline solution, which are prepared by a compounding pharmacy.

Facet Joint Injections/Medial Branch Blocks

Facet joint injections, also known as intra-articular injections (IA), are a minimally invasive procedure in which a physician injects a small amount of anesthetic, which may or may not contain a steroid, to numb the facet joint. An appropriately performed IA facet joint injection, in which the medication is only distributed to the joint capsule, can help to diagnosis facet joint pain. If the pain goes away after the IA injection, or is significantly decreased, then the facet joint can be determined to be the source of pain. While a good diagnostic tool for facet-mediated pain, IA is less predictive than medial branch blocks to medial branch radiofrequency ablation.

Medial branch blocks (MBB) are also used to diagnose facet joint pain and may or may not contain a steroid. MBB may not achieve the level of specificity that an appropriately performed IA injection can. This is due to the fact that the medial branch is not encapsulated, and the medication can result in anesthesia of not only the medial branch, but also anesthesia of other nerves in close proximity. This could potentially result in non-selective neural blockade and a false-positive result. Even though this is a known possibility, MBB is an acceptable diagnostic

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test, and it is usually the preferred test when lumbar facet radiofrequency ablation is being considered. When used as a tool before lumbar facet neurolysis, MBB may be associated with a higher success rate than IA injections.

Once the facet joint has been determined to be the source of pain, a series of injections may be needed to establish consistency of results, especially if diagnostic facet joint injections/medial branch blocks are followed by neurolysis.

Image guidance has become an essential component of performing spinal procedures in pain management. For MBB and IA facet joint injections, fluoroscopy and to a lesser degree, CT guidance are most commonly used. The use of imaging allows accurate needle placement ensuring the lowest volume of anesthetic is administered, thereby reducing spread to surrounding tissues which may lead to false-positive results. Image guidance also improves safety as it helps to avoid unnecessary injury.

IV. RATIONALE

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Summary of Evidence

For individuals who have lumbar or cervical radiculopathy who receive ESI, the evidence includes RCTs and a number of systematic reviews and meta-analyses of these RCTs. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, medication use, and treatment-related morbidity. The evidence base lacks large-scale, high-quality trials and has a high degree of variability among the available trials in terms of patient populations, epidural injection techniques, and comparison treatments. The results of individual trials are mixed, with some reporting significant benefits for the ESI group and others reporting no benefit. Most systematic reviews did not perform pooled analyses due to the heterogeneity of trials. In the 2 reviews that reported quantitative results, short-term pain relief at up to 6 months follow-up was superior in patients treated with epidural steroids. None of the analyses reported long-term benefits for treatment with ESIs. Adverse events were generally mild but not well reported in these trials. Serious adverse events can occur, but their rate is unknown. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have spinal stenosis who receive ESIs, the evidence includes a moderately large RCT (N=400) and systematic reviews of these RCTs. Relevant outcomes include symptoms, functional outcomes, health status measures, quality of life, medication use, and treatment-related morbidity. The largest RCT and the majority of smaller trials did not report a benefit for ESIs. The evidence is insufficient to determine the effects of technology on health outcomes.

For individuals who have nonspecific low back pain who receive ESIs, the evidence includes systematic reviews of RCTs and nonrandomized studies. Relevant outcomes include symptoms, functional outcomes, health status measures, quality of life, medication use, and treatment-

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related morbidity. Most trials were of low quality and did not report a benefit for ESIs. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have back or neck pain who receive facet joint injections/medial branch blocks, the clinical evidence for the efficacy of these injections is considered limited. Based on consensus practice guidelines and standards of care for those in chronic pain, the evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

V. DEFINITIONS

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ARTHROGRAPHY is a diagnostic study that involves the injection of contrast media into a joint.

FACET JOINT refers to one of the zygapophyseal joints of the vertebral column between the articulating facets of each pair of vertebrae.

INTRAVENOUS refers to within or into a vein.

NERVE BLOCK refers to interruption of the conduction of impulses to peripheral nerves or nerve trunks by the injection of a local anesthetic solution.

NUMERIC PAIN RATING SCALE: A pain assessment system in which patients are asked to rate their pain on a scale from 1 to 10, with 10 representing the worst pain they have experienced or could imagine.

OFF-LABEL USE: The use of a prescription drug or medical device in the treatment of an illness or injury for which it has not been specifically approved by the FDA.

PARAVERTEBRAL refers to alongside or near the vertebral column.

RADICULOPATHY refers to any disease of a nerve root.

VISUAL ANALOG SCALE (VAS): A graphic scale that helps a patient to quantify pain, depression, and other subjective and otherwise unmeasurable states or conditions.

ZYGAPOPHYSEAL concerns a zygapophysis, one of the articular processes of a neural arch of a vertebra.

VI. BENEFIT VARIATIONS

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The existence of this medical policy does not mean that this service is a covered benefit under the member's health benefit plan. Benefit determinations are based on the applicable health benefit plan language. Medical policies do not constitute a description of benefits. Members and providers should consult the member's health benefit plan for information or contact Capital Blue Cross for benefit information.

VII. DISCLAIMER

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Capital Blue Cross' medical policies are developed to assist in administering a member's benefits. These medical policies do not constitute medical advice and are subject to change.

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Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member's benefit information, the benefit information will govern. If a provider or a member has a question concerning the application of this medical policy to a specific member's plan of benefits, please contact Capital Blue Cross' Provider Services or Member Services. Capital Blue Cross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. CODING INFORMATION

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Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Investigational; therefore, not covered, ultrasound guidance for facet joint injections:

Procedure Codes							
0213T	0214T	0215T	0216T	0217T	0218T		

Covered when medically necessary, facet joint nerve block injections:

Procedure Codes							
64490	64491	64492	64493	64494	64495		

ICD-10-CM Diagnosis Codes	Description
G54.1	Lumbosacral plexus disorders
G54.2	Cervical root disorders, not elsewhere classified
G54.3	Thoracic root disorders, not elsewhere classified
G54.4	Lumbosacral root disorders, not elsewhere classified
M08.1	Juvenile ankylosing spondylitis
M43.22	Fusion of spine, cervical region
M43.23	Fusion of spine, cervicothoracic region
M43.24	Fusion of spine, thoracic region
M43.25	Fusion of spine, thoracolumbar region
M43.26	Fusion of spine, lumbar region
M43.27	Fusion of spine, lumbosacral region
M43.28	Fusion of spine, sacral and sacrococcygeal region

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ICD-10-CM Diagnosis Codes	Description
M45.0	Ankylosing spondylitis of multiple sites in spine
M45.2	Ankylosing spondylitis of cervical region
M45.3	Ankylosing spondylitis of cervicothoracic region
M45.4	Ankylosing spondylitis of thoracic region
M45.5	Ankylosing spondylitis of thoracolumbar region
M45.6	Ankylosing spondylitis lumbar region
M45.7	Ankylosing spondylitis of lumbosacral region
M45.8	Ankylosing spondylitis sacral and sacrococcygeal region
M45.A0	Non-radiographic axial spondyloarthritis of unspecified sites in spine
M45.A1	Non-radiographic axial spondyloarthritis of occipito-atlanto-axial region
M45.A2	Non-radiographic axial spondyloarthritis of cervical region
M45.A3	Non-radiographic axial spondyloarthritis of cervicothoracic region
M45.A4	Non-radiographic axial spondyloarthritis of thoracic region
M45.A5	Non-radiographic axial spondyloarthritis of thoracolumbar region
M45.A6	Non-radiographic axial spondyloarthritis of lumbar region
M45.A7	Non-radiographic axial spondyloarthritis of lumbosacral region
M45.A8	Non-radiographic axial spondyloarthritis of sacral and sacrococcygeal region
M45.AB	Non-radiographic axial spondyloarthritis of multiple sites in spine
M46.02	Spinal enthesopathy, cervical region
M46.03	Spinal enthesopathy, cervicothoracic region
M46.04	Spinal enthesopathy, thoracic region
M46.05	Spinal enthesopathy, thoracolumbar region
M46.06	Spinal enthesopathy, lumbar region
M46.07	Spinal enthesopathy, lumbosacral region
M46.08	Spinal enthesopathy, sacral and sacrococcygeal region
M46.09	Spinal enthesopathy, multiple sites in spine
M46.1	Sacroilitis, not elsewhere classified
M47.012	Anterior spinal artery compression syndromes, cervical region
M47.013	Anterior spinal artery compression syndromes, cervicothoracic region
M47.014	Anterior spinal artery compression syndromes, thoracic region
M47.015	Anterior spinal artery compression syndromes, thoracolumbar region
M47.016	Anterior spinal artery compression syndromes, lumbar region
M47.022	Vertebral artery compression syndromes, cervical region
M47.12	Other spondylosis with myelopathy, cervical region
M47.13	Other spondylosis with myelopathy, cervicothoracic region

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ICD-10-CM Diagnosis Codes	Description
M47.14	Other spondylosis with myelopathy, thoracic region
M47.15	Other spondylosis with myelopathy, thoracolumbar region
M47.16	Other spondylosis with myelopathy, lumbar region
M47.22	Other spondylosis with radiculopathy, cervical region
M47.23	Other spondylosis with radiculopathy, cervicothoracic region
M47.24	Other spondylosis with radiculopathy, thoracic region
M47.25	Other spondylosis with radiculopathy, thoracolumbar region
M47.26	Other spondylosis with radiculopathy, lumbar region
M47.27	Other spondylosis with radiculopathy, lumbosacral region
M47.28	Other spondylosis with radiculopathy, sacral and sacrococcygeal region
M47.812	Spondylosis without myelopathy or radiculopathy, cervical region
M47.813	Spondylosis without myelopathy or radiculopathy, cervicothoracic region
M47.814	Spondylosis without myelopathy or radiculopathy, thoracic region
M47.815	Spondylosis without myelopathy or radiculopathy, thoracolumbar region
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region
M47.818	Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region
M47.892	Other spondylosis, cervical region
M47.893	Other spondylosis, cervicothoracic region
M47.894	Other spondylosis, thoracic region
M47.895	Other spondylosis, thoracolumbar region
M47.896	Other spondylosis, lumbar region
M47.897	Other spondylosis, lumbosacral region
M47.898	Other spondylosis, sacral and sacrococcygeal region
M48.02	Spinal stenosis, cervical region
M48.03	Spinal stenosis, cervicothoracic region
M48.04	Spinal stenosis, thoracic region
M48.05	Spinal stenosis, thoracolumbar region
M48.061	Spinal stenosis, lumbar region without neurogenic claudication
M48.062	Spinal stenosis, lumbar region with neurogenic claudication
M48.07	Spinal stenosis, lumbosacral region
M48.08	Spinal stenosis, sacral and sacrococcygeal region
M48.8X2	Other specified spondylopathies, cervical region
M48.8X3	Other specified spondylopathies, cervicothoracic region

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ICD-10-CM Diagnosis Codes	Description
M48.8X4	Other specified spondylopathies, thoracic region
M48.8X5	Other specified spondylopathies, thoracolumbar region
M48.8X6	Other specified spondylopathies, lumbar region
M48.8X7	Other specified spondylopathies, lumbosacral region
M48.8X8	Other specified spondylopathies, sacral and sacrococcygeal region
M50.01	Cervical disc disorder with myelopathy, high cervical region
M50.021	Cervical disc disorder at C4-C5 level with myelopathy
M50.022	Cervical disc disorder at C5-C6 level with myelopathy
M50.023	Cervical disc disorder at C6-C7 level with myelopathy
M50.03	Cervical disc disorder with myelopathy, cervicothoracic region
M50.11	Cervical disc disorder with radiculopathy, high cervical region
M50.121	Cervical disc disorder at C4-C5 level with radiculopathy
M50.122	Cervical disc disorder at C5-C6 level with radiculopathy
M50.123	Cervical disc disorder at C6-C7 level with radiculopathy
M50.13	Cervical disc disorder with radiculopathy, cervicothoracic region
M50.21	Other cervical disc displacement, high cervical region
M50.221	Other cervical disc displacement at C4-C5 level
M50.222	Other cervical disc displacement at C5-C6 level
M50.223	Other cervical disc displacement at C6-C7 level
M50.23	Other cervical disc displacement, cervicothoracic region
M50.31	Other cervical disc degeneration, high cervical region
M50.321	Other cervical disc degeneration at C4-C5 level
M50.322	Other cervical disc degeneration at C5-C6 level
M50.323	Other cervical disc degeneration at C6-C7 level
M50.33	Other cervical disc degeneration, cervicothoracic region
M50.81	Other cervical disc disorders, high cervical region
M50.821	Other cervical disc disorders at C4-C5 level
M50.822	Other cervical disc disorders at C5-C6 level
M50.823	Other cervical disc disorders at C5-C6 level
M50.83	Other cervical disc disorders, cervicothoracic region
M51.04	Intervertebral disc disorders with myelopathy, thoracic region
M51.05	Intervertebral disc disorders with myelopathy, thoracolumbar region
M51.06	Intervertebral disc disorders with myelopathy, lumbar region
M51.14	Intervertebral disc disorders with radiculopathy, thoracic region
M51.15	Intervertebral disc disorders with radiculopathy, thoracolumbar region

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ICD-10-CM Diagnosis Codes	Description
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M51.24	Other intervertebral disc displacement, thoracic region
M51.25	Other intervertebral disc displacement, thoracolumbar region
M51.26	Other intervertebral disc displacement, lumbar region
M51.27	Other intervertebral disc displacement, lumbosacral region
M51.34	Other intervertebral disc degeneration, thoracic region
M51.35	Other intervertebral disc degeneration, thoracolumbar region
M51.360	Other intervertebral disc degeneration, lumbar region with discogenic back pain only
M51.361	Other intervertebral disc degeneration, lumbar region with lower extremity pain only
M51.362	Other intervertebral disc degeneration, lumbar region with discogenic back pain and lower extremity pain
M51.369	Other intervertebral disc degeneration, lumbar region without mention of lumbar back pain or lower extremity pain
M51.370	Other intervertebral disc degeneration, lumbosacral region with discogenic back pain only
M51.371	Other intervertebral disc degeneration, lumbosacral region with lower extremity pain only
M51.372	Other intervertebral disc degeneration, lumbosacral region with discogenic back pain and lower extremity pain
M51.379	Other intervertebral disc degeneration, lumbosacral region without mention of lumbar back pain or lower extremity pain
M51.84	Other intervertebral disc disorders, thoracic region
M51.85	Other intervertebral disc disorders, thoracolumbar region
M51.86	Other intervertebral disc disorders, lumbar region
M51.87	Other intervertebral disc disorders, lumbosacral region
M53.2X7	Spinal instabilities, lumbosacral region
M53.2X8	Spinal instabilities, sacral and sacrococcygeal region
M53.3	Sacrococcygeal disorders, not elsewhere classified
M53.82	Other specified dorsopathies, cervical region
M53.83	Other specified dorsopathies, cervicothoracic region
M53.84	Other specified dorsopathies, thoracic region
M53.85	Other specified dorsopathies, thoracolumbar region
M53.86	Other specified dorsopathies, lumbar region
M53.87	Other specified dorsopathies, lumbosacral region

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ICD-10-CM Diagnosis Codes	Description
M53.88	Other specified dorsopathies, sacral and sacrococcygeal region
M54.2	Cervicalgia
M54.31	Sciatica, right side
M54.32	Sciatica, left side
M54.41	Lumbago with sciatica, right side
M54.42	Lumbago with sciatica, left side
M54.5	Low back pain
M54.50	Low back pain, unspecified
M54.51	Vertebrogenic low back pain
M54.59	Other low back pain
M54.6	Pain in thoracic spine
M54.89	Other dorsalgia
M62.830	Muscle spasm of back
M62.85	Dysfunction of the multifidus muscles, lumbar region
M96.1	Post-laminectomy syndrome, not elsewhere classified
M99.21	Subluxation stenosis of neural canal of cervical region
M99.22	Subluxation stenosis of neural canal of thoracic region
M99.23	Subluxation stenosis of neural canal of lumbar region
M99.24	Subluxation stenosis of neural canal of sacral region
M99.31	Osseous stenosis of neural canal of cervical region
M99.32	Osseous stenosis of neural canal of thoracic region
M99.33	Osseous stenosis of neural canal of lumbar region
M99.34	Osseous stenosis of neural canal of sacral region
M99.41	Connective tissue stenosis of neural canal of cervical region
M99.42	Connective tissue stenosis of neural canal of thoracic region
M99.43	Connective tissue stenosis of neural canal of lumbar region
M99.44	Connective tissue stenosis of neural canal of sacral region
M99.51	Intervertebral disc stenosis of neural canal of cervical region
M99.52	Intervertebral disc stenosis of neural canal of thoracic region
M99.53	Intervertebral disc stenosis of neural canal of lumbar region
M99.54	Intervertebral disc stenosis of neural canal of sacral region
M99.61	Osseous and subluxation stenosis of intervertebral foramina of cervical region
M99.62	Osseous and subluxation stenosis of intervertebral foramina of thoracic region

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ICD-10-CM Diagnosis Codes	Description
M99.63	Osseous and subluxation stenosis of intervertebral foramina of lumbar region
M99.64	Osseous and subluxation stenosis of intervertebral foramina of sacral region
M99.71	Connective tissue and disc stenosis of intervertebral foramina of cervical region
M99.72	Connective tissue and disc stenosis of intervertebral foramina of thoracic region
M99.73	Connective tissue and disc stenosis of intervertebral foramina of lumbar region
M99.74	Connective tissue and disc stenosis of intervertebral foramina of sacral region
S13.4XXA	Sprain of ligaments of cervical spine, initial encounter
S13.4XXD	Sprain of ligaments of cervical spine, subsequent encounter
S13.8XXA	Sprain of joints and ligaments of other parts of neck, initial encounter
S13.8XXD	Sprain of joints and ligaments of other parts of neck, subsequent encounter
S14.2XXA	Injury of nerve root of cervical spine, initial encounter
S14.2XXD	Injury of nerve root of cervical spine, subsequent encounter
S16.1XXA	Strain of muscle, fascia and tendon at neck level, initial encounter
S16.1XXD	Strain of muscle, fascia and tendon at neck level, subsequent encounter
S23.3XXA	Sprain of ligaments of thoracic spine, initial encounter
S23.3XXD	Sprain of ligaments of thoracic spine, subsequent encounter
S24.2XXA	Injury of nerve root of thoracic spine, initial encounter
S24.2XXD	Injury of nerve root of thoracic spine, subsequent encounter
S33.5XXA	Sprain of ligaments of lumbar spine, initial encounter
S33.5XXD	Sprain of ligaments of lumbar spine, subsequent encounter
S33.6XXA	Sprain of sacroiliac joint, initial encounter
S33.6XXD	Sprain of sacroiliac joint, subsequent encounter
S33.8XXA	Sprain of other parts of lumbar spine and pelvis, initial encounter
S33.8XXD	Sprain of other parts of lumbar spine and pelvis, subsequent encounter
S34.21XA	Injury of nerve root of lumbar spine, initial encounter
S34.21XD	Injury of nerve root of lumbar spine, subsequent encounter
S34.22XA	Injury of nerve root of sacral spine, initial encounter
S34.22XD	Injury of nerve root of sacral spine, subsequent encounter
S34.4XXA	Injury of lumbosacral plexus, initial encounter
S34.4XXD	Injury of lumbosacral plexus, subsequent encounter

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Investigational; therefore, not covered, epidural steroid injections without imaging guidance:

Procedure Codes							
62320	62322						

Covered when medically necessary, epidural steroid injections:

Procedure Codes							
62321	62323	64479	64480	64483	64484	77002	

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

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MP 4.014	02/12/2020 Consensus Review. Policy statement unchanged. References updated
	11/17/2020 Administrative Update. Codes 0228T, 0229T, 0230T and 0231T deleted. Effective 01/01/2021.
	01/08/2021 Consensus Review. Policy statement unchanged. References updated. Coding reviewed.
	09/07/2021 Administrative Update. Addition of new ICD-10 codes. Effective date 10/01/2021.
	11/22/2022 Consensus Review. For clarity, changed statement section heading from “Facet Joint Nerve Block Injections” to “Facet Joint Injections/Medial Branch Blocks”. No change to intent or coverage. Updated cross-references, FEP, Background, Rationale, and references. Updated coding table.
	12/01/2023 Minor Review. To facet joint/medial branch block, separated out sections with updated criteria for initial diagnostic injection, second diagnostic injection, and therapeutic injections. To epidural section, clarified which approach is eligible for multi-levels and updated time between injections as 14

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	days instead of 30 days. Updated policy guidelines and references. No changes to coding.
	08/15/2024 Administrative Update. Added/deleted codes as part of New Code Process. Eff date 10/01/2024.
	12/16/2024 Minor Review. Revised criteria for Epidural Steroid Injections. Updated background, rational, dx codes, and references. Procedure codes 62320 and 62322 moved to INV coding table. 77002 added to the policy.

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