Epidural Steroid Injections for Neck or Back Pain

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Blue KC has developed medical policies that serve as one of the sets of guidelines for coverage decisions. Benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in the medical policies. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and/or federal law. Medical policy does not constitute plan authorization, nor is it an explanation of benefits.

When reviewing for a Medicare beneficiary, guidance from National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) supersede the Medical Policies of Blue KC. Blue KC Medical Policies are used in the absence of guidance from an NCD or LCD.

Policy
Blue Cross and Blue Shield of Kansas City (Blue KC) will provide coverage for Epidural Steroid Injections for Back Pain when it is determined to be medically necessary because the criteria shown below are met.

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

Repeat treatment of persistent pain due to lumbar or cervical radiculopathy/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 Considerations for maximum number of injections); AND
- No more than 6 injections given over a 12 month period.

Simultaneous treatment of two vertebral levels may be considered medically necessary if criteria are met at each level.

**When Policy Topic is not covered**
Repeat treatment is considered not medically necessary if the initial treatment did not result in substantial pain relief.

Simultaneous treatment of more than two vertebral levels is considered not medically necessary.

Epidural steroid injections are considered investigational in all other situations, including but not limited to treatment of spinal stenosis and nonspecific low back pain.

The use of fluorography (imaging of the epidural space) as a component of epidural steroid injections is considered incidental and is not separately payable.

**Considerations**
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 a herniated disc.

Several aspects of epidural steroid injection therapy 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 recommend that no more than 3 injections should be given in 1 year, but
other experts believe that more than 3 per 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 patient could not tolerate physical therapy, AND
- Evaluation and appropriate management of associated cognitive and behavioral issues

See the Codes table for details.

### Description of Procedure or Service

<table>
<thead>
<tr>
<th>Populations</th>
<th>Interventions</th>
<th>Comparators</th>
<th>Outcomes</th>
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</table>
| **Individuals:** With lumbar or cervical radiculopathy | **Interventions of interest are:** Epidural steroid injections | **Comparators of interest are:** Conservative care (eg, physical therapy, medications, other nonpharmacologic measures) | **Relevant outcomes include:**
  - Symptoms
  - Functional outcomes
  - Health status measures
  - Quality of life
  - Medication use
  - Treatment-related morbidity |
| **Individuals:** With spinal stenosis | **Interventions of interest are:** Epidural steroid injections | **Comparators of interest are:** Conservative care (eg, physical therapy, medications, other nonpharmacologic measures) | **Relevant outcomes include:**
  - Symptoms
  - Functional outcomes
  - Health status measures
  - Quality of life
  - Medication use
  - Treatment-related morbidity |
| **Individuals:** With nonspecific low back pain | **Interventions of interest are:** Epidural steroid injections | **Comparators of interest are:** Conservative care (eg, physical therapy, medications, other nonpharmacologic measures) | **Relevant outcomes include:**
  - Symptoms
  - Functional outcomes
  - Health status measures
  - Quality of life
  - Medication use
  - Treatment-related morbidity |
Epidural steroid injections (ESIs) are a treatment for neck or back pain that has not responded to conservative measures. Local steroid injections may improve pain by reducing inflammation, thus relieving pressure on nerve roots or other structures that may be the origin of pain.

For individuals who have lumbar or cervical radiculopathy who receive ESI, the evidence includes many small randomized controlled trials (RCTs) and a number of systematic reviews of these RCTs. The 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 two reviews that reported quantitative results, short-term pain relief at up to six 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, a few small RCTs, and systematic reviews of these RCTs. The 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 a number of small RCTs and systematic reviews of these RCTs. The relevant outcomes include symptoms, functional outcomes, health status measures, quality of life, medication use, and treatment-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.

**Background**

**Back Pain**

Back pain is an extremely common condition. Most episodes are self-limited and will resolve within one month, but a small percentage will persist and become chronic. Patients with chronic back pain may suffer from a 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 the overtreatment of patients who may not benefit from interventions for back pain.²

**Sciatica**
Back pain can result from a variety of underlying causes. Sciatica is a subset of low back pain that is associated with irritation of one or more lumbar spinal nerve roots, which results in symptoms of radiculopathy. Symptoms of radiculopathy include pain that radiates down the leg to below the knee, numbness, muscle weakness, and lack of reflexes in a dermatomal distribution.³ Most patients with sciatica 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 the 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. The 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 the 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 nonradicular 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.¹
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 (eg, soft tissues, intraspinal, sacroiliac joints) and can use different therapeutic agents (eg, botulinum toxin, steroids, proteolytic enzymes). Other interventional techniques include radiofrequency ablation, 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 second-line 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, transfartaminal, caudal). In addition, epidural steroid injections may be administered with or without fluoroscopic guidance. For example, a national survey published in 2002 reported that 30% of academic institutions and 77% of private practices use fluoroscopy. 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 one to three injections, each performed at least one 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 six 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.

**Rationale**

This evidence review was created in October 2014 and has been updated regularly with searches of the MEDLINE database. The most recent literature update was performed through August 28, 2019.
Evidence reviews assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are the length of life, quality of life (QOL), and ability to function—including benefits and harms. Every clinical condition has specific outcomes that are important to patients and managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of technology, two domains are examined: the relevance, and quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

The evidence base on the efficacy of epidural steroid injections (ESIs) for neck or back pain is large, with many RCTs and numerous systematic reviews of RCTs published. This literature review, therefore, concentrates on a representative sample of the available systematic reviews of RCTs, emphasizing those published most recently.

**Neck or Back Pain**

**Clinical Context and Therapy Purpose**
The purpose of ESIs for patients who have lumbar or cervical radiculopathy, who have spinal stenosis, or who suffer from nonspecific low back pain is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does the use of ESIs improve the net health outcome for those who suffer from lumbar or cervical radiculopathy, spinal stenosis, or nonspecific low back pain?

The following PICOs were used to select literature to inform this review.

**Patients**
The relevant populations of interest are individuals with lumbar or cervical radiculopathy, spinal stenosis, or nonspecific low back pain.

**Interventions**
The therapy being considered is ESI.

**Comparators**
The following practice is currently being used to treat lumbar or cervical radiculopathy, spinal stenosis, and nonspecific low back pain: conservative care, which can include physical therapy, medications, and other nonpharmacologic measures.

**Outcomes**
The general outcomes of interest for all three indications are reductions in pain and medication usage, and improvement in functional outcomes and QOL. Reductions in pain and medication use can be observed within a week. The duration of pain relief with corticosteroids is rarely longer than three months, so outcomes should be measured within this window.

**Lumbar Radiculopathy or Sciatica**

**Systematic Reviews**
Smith et al (2019) published the results of a systematic review of 19 studies assessing the efficacy of lumbar transforaminal steroid injection for radicular pain due to lumbar disc herniation. Placebo-controlled RCTs, pragmatic studies, and observational studies were included in the analysis. Utilizing a threshold of ≥50% reduction in pain, treatment success rates across studies were 63% (Range: 58 to 68%) at 1-month, 74% (Range: 68-80%) at 3-months, 64% (59-69%) at 6-months, and 64% (57-71%) at 1-year.

Arirachakaran et al (2018) conducted a systematic review comparing treatment with ESI (n=502) and placebo (n=504) in patients with moderate-to-severe back pain and radicular leg pain following discectomy for lumbar disc herniation. A total of 12 studies were pooled for the meta-analysis. The mean difference in visual analog scale (VAS) pain score for back pain at 1 week and 1 month was -0.53 (95% confidence interval [CI]: -1.42 to 0.36) and -0.89 (95% CI: -1.36 to -0.42) lower compared to placebo. The mean difference in VAS pain score for leg pain at 1 week and 1 month was -0.63 (95% CI: -0.75 to -0.50) and -0.47 (95% CI: -0.78 to -0.15) lower compared to placebo. Morphine consumption decreased by -8.47 mg (95% CI: -16.16 to -0.78 mg) compared to placebo. As included studies utilized mean follow-up durations ranging from one-week to one-month, this review did not evaluate long-term outcomes.

Bhatia et al (2016) published the results of a systematic review and meta-analysis of 8 RCTs including 771 patients (366 in steroid and 405 in comparator groups) that evaluated transforaminal ESIs to treat lumbosacral radicular pain secondary to herniated intervertebral discs. The control groups received local anesthetic with saline or saline alone. The strength of evidence for each included study was classified with the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system. Of the eight studies included, two were rated as high-risk of bias, two with unclear risk of bias, and four with low-risk of bias. Although this review minimized variability by including
studies that used only transforaminal administration of steroid as opposed to interlaminar and caudal administration, reviewers acknowledged variability on account of steroid dose, frequency, and the number of procedures. Reported results indicated that 3 months of ESI resulted in statistically significant but clinically modest reduction of 0.97 points in mean pain scores (0 to 10 scale) (95% CI, -1.42 to -0.51; p < 0.001, \( I^2 = 90\% \)) compared with local anesthetic or saline with a GRADE weak recommendation based on moderate-quality evidence. Epidural steroids did not decrease physical disability at 1 to 3 months after the intervention (GRADE strong recommendation based on high-quality evidence) or incidence of surgery at 12 months after the intervention (GRADE strong recommendation based on moderate-quality evidence) compared with local anesthetic or saline. Reviewers concluded that well-designed, large, RCTs would be required to evaluate appropriate dosages, adverse events, number of procedures, and measure the effect on psychological disability and QOL.

A systematic review of ESIs for the management of sciatica was published by Pinto et al (2012).\(^3\) This review included RCTs that provided information on at least one of the outcomes of overall pain, leg pain, back pain, or disability status. Twenty-five publications were included in the review, representing 23 unique trials. Trial sample sizes ranged from 23 to 325 patients, with most studies enrolling fewer than 100 patients. Using the GRADE classification, the level of quality was determined to be high for each outcome. Pooled results for each of the outcomes are summarized in Table 1. The magnitude of the between-group differences is small and statistically significant only for the outcomes of short-term leg pain and short-term disability. The greatest magnitude of the difference was 6.2 units on the VAS for short-term leg pain. This magnitude of the difference is below the minimally important difference for a 0 to 100 pain scale, which is generally considered to be in the range of 10 to 30 units.\(^{10}\)

**Table 1. Results From a Systematic Review Assessing ESIs for the Management of Sciatica**

<table>
<thead>
<tr>
<th>Outcome (0-100 Scale)</th>
<th>Weighted Mean Difference Between Groups (95% CI)</th>
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<tbody>
<tr>
<td></td>
<td><strong>Short-Term</strong></td>
</tr>
<tr>
<td>Leg pain</td>
<td>-6.2 (-9.0 to -3.0)</td>
</tr>
<tr>
<td>Back pain</td>
<td>0.5 (-3.9 to 4.8)</td>
</tr>
<tr>
<td>Disability</td>
<td>-3.1 (-5.0 to -1.2)</td>
</tr>
</tbody>
</table>

Adapted from Pinto et al (2012).\(^3\)

CI: confidence interval; ESI: epidural steroid injection.

Benyamin et al (2012) published a systematic review that included RCTs and non-RCTs of epidural injections in patients with low back pain and/or leg pain.\(^{24}\) Nineteen studies met the inclusion criteria. Most of these trials (13/19) compared epidural steroids with active control, and 5 of 19 used a placebo control. A qualitative summary of studies was performed, without any quantitative meta-analysis. Subgroup analysis was performed on studies that included patients with disc herniation and radiculopathy. Reviewers also separated the intervention into
studies that used fluoroscopic guidance. Of the eight studies that did, all reported short-term results that favored ESIs. Among four trials that reported longer-term follow-up at one year, results from two were positive and two were negative.

Chou et al (2009) reviewed the evidence for ESIs in the treatment of low back pain with radiculopathy, as part of their examination of nonsurgical interventional therapies for low back pain.4 Reviewers identified 17 RCTs reporting on short-term benefit, and 4 RCTs reporting on longer-term benefit. For short-term benefits, the results were mixed. Ten of the 17 trials reported no benefit for ESIs, and 7 of 17 reported a statistically significant benefit. Of the seven trials rated higher quality, four of seven reported a benefit for ESIs and three of seven reported no benefit. Subgroup analysis by type of placebo control (epidural or soft-tissue injection) revealed that most trials using a soft-tissue control injection (5/6) reported a benefit, while most of the trials using an epidural control injection (9/11) reported no benefit. Other subgroup analyses based on the duration of symptoms, use of imaging to confirm prolapsed disc, and study quality did not show any significant differences.

Randomized Controlled Trials
Several individual RCTs have been completed since publication of the most recent systematic reviews.11,12,13 These trials have corroborated the results of previous research, generally reporting a small benefit for treatment with ESI. The largest of these trials was a double-blind, sham-controlled study reported by Cohen et al (2015) that compared ESI with gabapentin in 145 patients who had lumbar radiculopathy.11 There were no differences between groups for the primary outcome of change in pain scores. At 1 month, the change in pain scores in the ESI group was -2.2 vs -1.7 in the gabapentin group (p=0.25); at 3 months, the change in pain scores were -2.0 in the ESI group vs -1.6 in the gabapentin group (p=0.43). ESI was superior to gabapentin on some secondary outcomes at 1 month (eg, percent successful outcome, 66% in ESI group vs 46% in gabapentin group; p=0.02); however, at 3 months, these differences were not significant.

In the RCT with the longest follow-up of 2 years, Manchikanti et al (2014) randomized 120 patients to ESI or sham control.13 Primary outcome measures were at least 50% improvement on the Oswestry Disability Index score and the numeric rating scale score for pain. There were no differences between groups reporting a good response, with 57% in the ESI group and 65% in the sham group reporting at least a 50% improvement at 2 years (p=NS). Another RCT, reported by Spijker-Huiges et al (2014), allocated 63 patients from general medical practices in the Netherlands to usual care or usual care plus 1 injection of ESI.12 The main outcomes were a change in numeric rating scale pain scores and the Roland-Morris Disability Questionnaire (RMDQ) scores (range, 0-24; higher scores indicate greater disability). A small, statistically significant difference was found favoring the ESI group on both outcomes but was considered too small to be clinically relevant.

Cervical Radiculopathy
Systematic Reviews
There are a smaller number of published trials on the use of epidural steroids for cervical radiculopathy. Two systematic reviews were identified that summarized the literature on cervical epidural injections for the treatment of cervical radiculopathy.

Diwan et al (2012) performed a systematic review of ESIs for chronic neck and upper-extremity pain and reported separately on the evidence for cervical radiculopathy. This analysis included 4 RCTs, 3 of which were included in the review by Benyamin et al (2009), discussed next. The fourth RCT, which was the largest (n=120) and rated the highest in quality, randomized patients to epidural steroid plus local anesthetic or local anesthetic alone, and reported on pain relief at 6 and 12 months. At 6 months, the percentage of patients experiencing pain relief was 82% for the steroid group vs 73% for the control group, a difference that was not statistically significant. At 12 months, outcomes were also similar, with 72% of patients in the steroid group reporting pain relief compared with 68% in the control group.

A review by Benyamin et al (2009) included studies of epidural injections for neck pain that was present for more than 3 months, with or without radiculopathy. Reviewers identified three RCTs that met inclusion criteria, all of which treated patients with cervical radiculopathy, but only one of which compared epidural steroids with a control condition. One of the other trials compared two different preparations of steroids, and the third trial compared steroids plus morphine with steroids alone. In the single trial comparing steroids with control, 42 patients were randomized to ESIs (n=24) or to steroid injections in the adjacent neck muscle (n=18). One week after the last epidural injection, more patients in the epidural group reported good pain relief compared with control (76% vs 36%, p not reported), and at 1-year follow-up, the difference in the percentage of patients reporting good pain improvement persisted in favor of the epidural steroid group (68% vs 12%, p not reported).

Randomized Controlled Trials
Since these systematic reviews were published, Cohen et al (2014) reported the results of an RCT that compared ESI, conservative treatment, and a combination of both for patients with cervical radiculopathy. A total of 169 patients were randomized to conservative care (physical therapy plus medications), ESIs, or a combination of both treatments. The primary outcomes were neck and arm pain measured at one and three months posttreatment. There were no differences noted between ESI and conservative care on any of the outcome measures. The group receiving combination therapy had a greater reduction in arm pain at 1 month compared with the 2 individual treatments and had a greater success rate at 3 months (56.9% vs 26.8%, p=0.006).

Section Summary: Lumbar Radiculopathy or Sciatica and Cervical Radiculopathy
There are a large number of small RCTs evaluating ESIs for treatment of lumbar radiculopathy or sciatica and cervical radiculopathy, and a number of systematic
reviews summarizing these trials. For short-term pain relief, the direction of benefit in virtually all trials favored epidural injections, and the differences between groups examined in the studies were statistically significant in some trials but not others. Most systematic reviews did not perform a quantitative meta-analysis, thus limiting their ability to examine these small trials with increased power. In a meta-analysis that reported pooled results, there was a statistically significant reduction in pain at 6 months, but the mean difference was less than the minimally important clinical difference for a 0-to-100 VAS designated for pain measurement. For long-term pain relief at one year or beyond, most trials have reported negative results and lacked pooled analysis of significant differences.

### Spinal Stenosis

#### Systematic Reviews

Smith et al (2019) identified 11 studies assessing the efficacy of transforaminal ESI in patients with radicular pain due to spinal stenosis. Utilizing a threshold of ≥50% reduction in pain, treatment success rates across studies were 49% (Range: 43 to 55%) at 1-month, 48% (Range: 35 to 61%) at 3-months, 43% (Range: 33 to 53%) at 6-months, and 59% (Range: 45 to 73%) at 1-year. However, the authors noted that these results lacked adequate corroboration from appropriately controlled RCTs.

In the systematic review by Benyamin et al (2012), 6 RCTs assessed patients with spinal stenosis, 5 of which compared steroid injections with a local anesthetic alone. Two trials reported between-group differences in favor of steroid injections, three reported significant improvement in pain for the steroid group but did not report between-group differences, and the other reported no significant improvement for the steroid group.

Manchikanti et al (2012) identified 4 RCTs of ESIs for the treatment of lumbar spinal stenosis. Although two compared epidural steroids with control and reported on pain relief and/or disability, neither reported that pain relief with epidural steroids was superior to control, either in the short- or the long-term.

The systematic review by Diwan et al (2012) identified 1 RCT that treated cervical spinal stenosis in 60 patients. In this trial, there were no significant differences in the percentages of patients reporting pain relief in the epidural group compared with control at 6 months (87% vs 80%) or at 12 months (73% vs 70%).

The systematic review by Chou et al (2009) identified 3 small placebo-controlled trials on the treatment of spinal stenosis, but in 2 of them, only a subset of treated patients had spinal stenosis. Reviewers rated the quality of this evidence as poor and concluded that it was not possible to determine whether epidural steroids offer a benefit for spinal stenosis.

#### Randomized Controlled Trials

Schneider et al (2019) published the results of a 3-arm RCT comparing the clinical effectiveness of medical care (n=88), group exercise (n=84), and manual
therapy/individualized exercise (n=87) in patients with lumbar spinal stenosis.\textsuperscript{17} Treatment in the medical care group consisted of medications and/or ESI provided by a physiatrist. Study limitations include failure to disclose the proportion of patients in the medical care group receiving ESI during the course of the study, excluding patients <60 years of age, and no direct reporting of pain outcomes. The primary outcomes were symptoms and physical function as measured by the patient-reported Swiss Spinal Stenosis (SSS) score. The SSS score ranges from 12 to 55 points, with higher scores indicating higher levels of self-reported disability. Analyses at 2 months indicated that manual therapy/individualized exercise demonstrated greater reduction in SSS score compared to medical care (-2.0; 95\% CI: -3.6 to -0.4) or group exercise (-2.4; 95\% CI: -4.1 to -0.8). The magnitude of the difference in the reduction of SSS score between groups did not reach the level of a minimal clinically important difference of 3.02 points.

A moderately large RCT of ESIs for the treatment of spinal stenosis was published by Friedly et al (2014).\textsuperscript{18} This double-blind trial randomized 400 patients with lumbar central spinal stenosis and at least moderate-to-severe leg pain (\ge 4 on 0-10 VAS) or disability (\ge 7 on RMDQ, 0-24 scale) due to spinal stenosis to treatment with ESIs plus lidocaine or lidocaine alone. One repeat injection could be given at three weeks at the discretion of the patient and treating physician. The primary outcomes were the patient’s rating of pain in the buttocks, hip, or leg at six weeks following the initial treatment and the RMDQ score at six weeks. Secondary outcomes included the same outcome measures at 3 weeks posttreatment, measures of back pain, percent responders (defined either as \ge 30\% reduction in pain, or \ge 50\% reduction in pain), and scores on several QOL scales. At the six-week follow-up, there were no significant differences in the primary outcomes between groups. The change in pain scores on the VAS for the steroid group was -2.8 compared with -2.6 for the control group (adjusted between-group mean difference, -0.2 points; 95\% CI, -0.8 to 0.4; \textit{p}=0.48), and the change in the RMDQ scores was -4.2 points for the steroid group vs -3.1 points for the control group (adjusted between-group mean difference, -1.0 points; 95\% CI, -2.1 to 0.1; \textit{p}=0.07). There were small, statistically significant differences in measures of pain and disability at three weeks, but these changes were less than the minimal clinical difference for the scales, and differences did not persist at six weeks. On the secondary outcomes at six weeks, there were generally no between-group differences except for two subscales of the QOL measures (symptoms of depression on 8-item Patient Health Questionnaire, and satisfaction on the Swiss Spinal Stenosis Questionnaire). Friedly et al (2017) published 12-month follow-up data because the trial protocol offered participants the option to crossover to the alternative treatment after 6 weeks while remaining masked to treatment assignment.\textsuperscript{19} Results showed that ESIs offered no benefits from 6 weeks to 12 months beyond that of injections of lidocaine alone in terms of self-reported pain and function or reduction in the use of opioids and spine surgery. At 12 months, the adjusted mean difference from baseline between groups was -0.4 for RMDQ score (95\% CI, 1.6 to 0.9) and was 0.1 for leg pain (95\% CI, -0.5 to 0.7).

\textbf{Section Summary: Spinal Stenosis}
A few RCTs have evaluated epidural steroids for spinal stenosis, and the published systematic reviews did not perform pooled analysis of the available trials. Most published trials did not report a significant benefit for epidural steroids, including a 2014 moderately large-sized RCT. This evidence does not support that ESIs improve outcomes for patients with spinal stenosis.

**Nonspecific Low Back Pain**

A Cochrane review by Staal et al (2008) assessed injection therapy for subacute and chronic low back pain. This review included RCTs enrolled patients with low back pain for at least one month and reported pain outcomes. Eighteen studies met the inclusion criteria, ten of which were considered to be at low risk for bias. Due to high levels of heterogeneity, a pooled analysis was not performed. Of the 18 selected studies, 5 reported a benefit for treatment with epidural steroids. There were two placebo-controlled studies of short-term outcomes of leg pain. Neither study reported a significant reduction of pain associated with epidural injections. Three studies compared epidural steroids with nonsteroidal anti-inflammatory drugs, and none of them reported significant improvements for patients treated with epidural steroids.

The review by Benyamin et al (2012) identified 3 trials of ESIs for nonspecific low back pain, 1 randomized and 2 nonrandomized. The randomized trial reported a greater percentage of patients with pain relief following ESI (83%) compared with local anesthetic alone (73%), but this between-group difference was not statistically significant. The two nonrandomized studies reported improvements for patients treated with epidural steroids, but no between-group comparisons were done.

Manchikanti et al (2012) addressed the indication of nonspecific low back pain (axial low back pain) in their systematic review. However, no RCTs met their inclusion criteria, and only three nonrandomized studies were included. This evidence was insufficient to inform conclusions on the efficacy of epidural steroids for nonspecific low back pain.

**Section Summary: Nonspecific Low Back Pain**

The evidence on ESIs for nonspecific low back pain is limited. Small RCTs have been published, but they were generally judged to be of low quality, and most studies did not report significant improvements in the group receiving ESIs.

**Safety**

Potential adverse events of ESIs can include complications of the injection itself, such as inadvertent puncture of the dura, bleeding, and infections. Additional complications may be related to the administration of steroids, including suppression of the hypothalamic-pituitary axis and the immune system.

In the systematic review by Chou et al (2009), it was noted that while case reports have reported serious adverse events such as paralysis and infection due to epidural injections, serious adverse events were rarely reported in the clinical trials. Of the 17 trials included in the review that reported on the use of epidural
injections for treatment of low back pain with radiculopathy, 10 of 17 did not report adverse events at all, and the adverse events reported in the other trials were generally transient and mild. In 1 high-quality trial with systematic reporting of adverse events, 3.3% (4/120) of patients experienced a postinjection headache, 0.8% (1/120) experienced post-dural puncture headache, 1.7% (2/120) experienced postinjection nausea, and 4.2% (5/120) experienced other adverse events.

Adverse events of ESIs are not well reported in treatment trials. In a systematic review by Koes et al (1995), only 4 of 15 included trials reported on adverse events. In addition to this lack of reporting, the available trials are generally small and therefore inadequate for determining rates of uncommon adverse events. A consensus panel (2015) convened in part by the U.S. Food and Drug Administration (FDA) reviewed the literature on serious neurologic complications following ESI. The evidence was restricted to case reports and reports of malpractice claims. Reports included direct needle injury to the spinal cord, arterial injury, swelling of an unrecognized epidural lesion, and paraplegia/stroke. Based on the pattern of reports, the report concluded that stroke and paraplegia were likely caused by intraarticular injection of particulate steroids. Therefore, the rate of adverse events is mostly uncertain.

The FDA (2014) issued a drug safety communication on rare but serious neurologic problems associated with ESIs. This communication stated that the safety of ESIs has not been established and that the FDA has not approved corticosteroids for this use. Potential serious adverse neurologic events include loss of vision, stroke, paralysis, and death. The FDA subsequently assembled an expert panel that issued a report in 2015. This report included a series of recommendations regarding the ESI technique, including clinically relevant issues related to its performance, such as the use of particulate steroids, use of contrast, and the use of sedation.

Epidural steroids are generally compounded medications because the specific preparations for clinical use are prepared at a pharmacy rather than by the manufacturer of the drug. In 2012, several patients were identified who developed fungal meningitis complications following ESI due to contaminated medication obtained from a single pharmacy. The U.S. Centers for Disease Control and Prevention subsequently obtained preliminary data on 137 patients across 10 states affected by this outbreak. Of those, 12 (9%) of 137 patients died, 3 (2%) of 137 had suffered a stroke, and 3 (2%) of 137 had osteomyelitis or epidural abscess. The contamination was attributed to faulty sterilization procedures at the pharmacy that compounded the medications.

Due to reports that transforaminal anterolateral ESI approaches may be associated with rare but serious complications, Bise et al (2019) compared the efficacy of transforaminal anterolateral against 2 recently described, potentially safer methods: transforaminal posterolateral and transfacet indirect approaches. The efficacy of transforaminal anterolateral, transforaminal posterolateral, and transfacet indirect ESI approaches was assessed in patients
with cervical radicular pain (n=104). The decrease in VAS did not differ between the 3 types of ESI at 6 weeks (p=0.635) or 6 months (p=0.529) and no complications were reported.

Section Summary: Safety
Adverse events, both minor and serious, can occur following ESIs. For serious neurologic events, the evidence consists of case reports and, as a result, the rate of serious adverse events is uncertain. Few serious adverse events have been reported in the RCTs, but there is also a lack of systematic reporting in the available trials. Minor adverse events that are self-limited (eg, headache) are more common, but the evidence is not sufficient to determine actual event rates. Further research is needed to determine the true rate of adverse events attributable to ESIs. An FDA consensus panel has issued guidelines for the technical performance of ESI with the goal of reducing potential serious neurologic events.

Summary of Evidence
For individuals who have lumbar or cervical radiculopathy who receive ESI, the evidence includes many small RCTs and a number of systematic reviews of these RCTs. The relevant outcomes are symptoms, functional outcomes, health status measures, QOL, 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 two reviews that reported quantitative results, short-term pain relief at up to six 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, a few small RCTs, and systematic reviews of these RCTs. The relevant outcomes include symptoms, functional outcomes, health status measures, QOL, 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 a number of small RCTs and systematic reviews of these RCTs. The relevant outcomes include symptoms, functional outcomes, health status measures, QOL, medication use, and treatment-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.
SUPPLEMENTAL INFORMATION

Clinical Input From Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

In response to requests, input was received from 5 academic medical centers and 6 specialty societies while this policy was in development in 2014. Consensus was reached among reviewers that: treatment of cervical radiculopathy is medically necessary with the same criteria as for lumbar radiculopathy; the minimum period of time for conservative therapy should be four weeks or less; fluoroscopic guidance should be used in all cases of epidural steroid injections; and, fluorography imaging of the epidural space is investigational. There was mixed input on the optimal timing to assess response, the number of levels that should be treated at one time, and the maximum number of injections to be given in one year.

Practice Guidelines and Position Statements

American Association of Neurological Surgeons

Updated guidelines on the performance of fusion procedures for degenerative disease of the lumbar spine from the American Association of Neurological Surgeons (2014) stated that lumbar epidural steroid injections (ESIs) are an option for short-term relief of chronic low back pain without radiculopathy in patients with degenerative disease of the lumbar spine (level III evidence).26, Caudal ESIs are an option for reducing low back pain without radiculopathy of greater than six weeks in duration in patients with degenerative disease of the lumbar spine (level III evidence).

Agency for Healthcare Research and Quality

The Agency for Healthcare Research and Quality (2014) issued an evidence-based practice center systematic review protocol.27 The protocol indicated that systematic reviews of injection therapies have come to conflicting conclusions regarding the benefits of injection therapies, and clinical practice guidelines provide discordant recommendations regarding their use. Important challenges in conducting a review of this topic include sparse data from randomized trials for most injection therapies (with the exception of epidural steroids), inconsistency of results across trials, as well as variability across studies in the methods used to select patients for inclusion, the specific techniques used, the comparisons evaluated, and the outcomes assessed.”

North American Spine Society
The NASS (2012) clinical guidelines on multidisciplinary spine care diagnosis and treatment of lumbar disc herniation with radiculopathy stated that no studies had directly addressed the role of ESIs or selective nerve root blocks in the diagnosis of patient selection for subsequent surgical treatment of a lumbar disc herniation with radiculopathy.28

The NASS (2011) revised its clinical guidelines on multidisciplinary spine care diagnosis and treatment of degenerative lumbar spinal stenosis.29 The NASS made the following recommendation: a multiple injection regimen of radiographically guided transforaminal ESI or caudal injections is suggested to produce medium-term (3 to 36 months) relief of pain in patients with radiculopathy or neurogenic intermittent claudication from lumbar spinal stenosis (grade C recommendation).

The NASS (2013) issued a review and recommendation statement on lumbar transforaminal ESIs (LTFESI).30 The following recommendations were made:

“Patients with lumbar sciotic stenosis and radiculopathy experience significantly higher success rates if their symptoms were present for less than three months. Level of evidence IV.”

“There is no significant difference between EMG [electromyography] positive and negative groups in terms of pain difference, but a mild functional improvement in an EMG positive patient undergoing LTFESI. Level of evidence V.”

The NASS (2011) issued a review and recommendation statement for cervical ESIs.31 The following recommendation was made: Both transforaminal and interlaminar ESIs may be considered to provide short- and long-term relief of cervical radiculitis (grade C recommendation).

**American Society of Anesthesiologists**
The guidelines on chronic pain management from the American Society of Anesthesiologists (2010) recommended that transforaminal epidural injections should be performed with appropriate image guidance to confirm correct needle position and spread of contrast before injecting therapeutic substances.32 Image guidance might be considered for interlaminar epidural injections to confirm correct needle position and spread of contrast before injecting therapeutic substance.

**American College of Physicians et al**
The American College of Physicians and the American Pain Society (2007) issued guidelines on the diagnosis and treatment of low back pain, which stated: “Patients with persistent low back pain and signs and symptoms of radiculopathy or spinal stenosis should be evaluated with MRI (preferred) or CT [computed tomography] only if they are potential candidates for surgery or ESI. (Strong recommendation, moderate-quality evidence).”33
The American Pain Society (2009) published guidelines on the use of interventional therapies for low back pain, based on a systematic review of the evidence published in the same year. These guidelines made the following recommendations on ESIs:

- “In patients with persistent radiculopathy due to herniated lumbar disc, it is recommended that clinicians discuss risks and benefits of epidural steroid injections as an option (weak recommendation, moderate-quality evidence). It is recommended that shared decision making regarding ESI include a specific discussion about inconsistent evidence showing moderate short-term benefits, and lack of long-term benefits.”
- There is “insufficient evidence ... to reliably judge benefits and harms” of ESI for spinal stenosis.
- “There is insufficient evidence to adequately evaluate benefits of local injections, botulinum toxin injection, ESI, intradiscal electrothermal therapy (IDET), therapeutic medial branch block, radiofrequency denervation, sacroiliac joint steroid injection, or intrathecal therapy with opioids or other medications for nonradicular back pain.”

American Society of Interventional Pain Physicians
The American Society of Interventional Pain Physicians (2013) updated its guidelines on interventional techniques in chronic spinal pain. The following recommendations were made on ESIs of the lumbar spine:

- “The evidence is good in managing disc herniation or radiculitis for caudal, interlaminar, and transforaminal epidural injections;
- [the evidence] is fair for axial or discogenic pain without disc herniation, radiculitis or facet joint pain with caudal, and interlaminar epidural injections, and limited for transforaminal epidural injections;
- [the evidence] is fair for spinal stenosis with caudal, interlaminar, and transforaminal epidural injections; and
- [the evidence] is fair for postsurgery syndrome with caudal epidural injections and limited with transforaminal epidural injections.”

The following recommendations were made regarding ESIs of the cervical spine:

- “The evidence is good for cervical interlaminar epidural injections for cervical disc herniation or radiculitis”; and
- “[the evidence] is fair for axial or discogenic pain, spinal stenosis, and post cervical surgery syndrome.”

American Academy of Neurology
The American Academy of Neurology (2007) published guidelines on the use of epidural steroids for lumbosacral radiculopathy. These guidelines made the following recommendations:

- “[E]pidural steroid injections may result in some improvement in radicular lumbosacral pain when determined between 2 and 6 weeks following the injection, compared to control treatment (Level C, Class I-III). The average magnitude of effect is small, and the generalizability of the observation is limited by the small number of studies, limited to highly selected patient
populations, the few techniques and doses studied, and variable comparison treatments.”

- “[I]n general, epidural steroid injections for radicular lumbosacral pain have shown no impact on average impairment of function, on need for surgery, or on long-term pain relief beyond 3 months. Their routine use for these indications is not recommended (Level B, Class I-III).”
- “[T]here is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain (Level U).”

**U.S. Preventive Services Task Force Recommendations**
Not applicable.

**Medicare National Coverage**
There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

**Ongoing and Unpublished Clinical Trials**
A search of ClinicalTrials.gov in September 2018 did not identify any ongoing or unpublished trials that would likely influence this review.

**REFERENCES**


**Billing Coding/Physician Documentation Information**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>62320</td>
<td>Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance</td>
</tr>
<tr>
<td>62321</td>
<td>Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)</td>
</tr>
<tr>
<td>62322</td>
<td>Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance</td>
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<tr>
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</tr>
</tbody>
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guidance (ie, fluoroscopy or CT)

**62324** Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance

**62325** Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)

**62326** Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance

**62327** Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)

**64479** Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level

**64480** Injection(s), anesthetic agent 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 and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

**64484** Injection(s), anesthetic agent 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)

**ICD-10 Codes:**

**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

**M48.00-** Spinal stenosis code range

**M48.08**

**M50.10-** Cervical disc disorders with radiculopathy code range

**M50.13**

**M51.14-** Thoracic, thoracolumbar or lumbosacral intervertebral disc disorders
M51.17  with radiculopathy code range
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
M96.1  Postlaminectomy syndrome, not elsewhere classified

62310 and 62311 deleted as of 1/1/2017

Additional Policy Key Words
N/A

Policy Implementation/Update Information
12/1/14  New Policy. Epidural steroid injections are medically necessary for treatment of lumbar sciatica/radiculopathy when criteria are met, not medically necessary if previous epidural injections were not successful, and investigational for all other situations
12/1/15  No policy statement changes.
4/1/16   Added CPT’s: 64479, 64480, 64483, 64484. No policy statement changes.
12/1/16  No policy statement changes.
12/1/17  No policy statement changes.
12/1/18  No policy statement changes.
12/1/19  No policy statement changes.
12/1/20  "Neck" added to policy title. First medically necessary indication updated to include neck.

State and Federal mandates and health plan contract language, including specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The medical policies contained herein are for informational purposes. The medical policies do not constitute medical advice or medical care. Treating health care providers are independent contractors and are neither employees nor agents Blue KC and are solely responsible for diagnosis, treatment and medical advice. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, photocopying, or otherwise, without permission from Blue KC.