

EPIDURAL STEROID AND FACET INJECTIONS FOR SPINAL PAIN

Policy Number: 2014T0004T
Effective Date: June 1, 2014

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INSTRUCTIONS FOR USE

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

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

BENEFIT CONSIDERATIONS

Essential Health Benefits for Individual and Small Group:

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits (“EHBs”). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the enrollee’s specific plan document to determine benefit coverage.

COVERAGE RATIONALE

Epidural steroid injections in this policy apply to the lumbar spine only. This section does not address cervical injections.

The facet joint injections section of this policy addresses multiple sites, and is not limited to the lumbar spine.

The use of ultrasound guidance for epidural steroid injection(s) and facet joint injection(s) is unproven and not medically necessary. There is insufficient clinical evidence regarding its safety and/or efficacy in published peer-reviewed medical literature. The available published evidence for ultrasound guidance for epidural and facet injections is limited to a small feasibility study and a cadaver study.

Epidural Steroid Injections

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

Epidural steroid injections have a clinically established role in the short-term management of low back pain when the following two criteria are met:

- The pain is associated with symptoms of nerve root irritation and/or low back pain due to disc extrusions and/or contained herniations; and
- The pain is unresponsive to conservative treatment, including but not limited to pharmacotherapy, exercise or physical therapy

Epidural steroid injection is unproven and not medically necessary for all other indications of the lumbar spine.

There is a lack of evidence from randomized controlled trials indicating that epidural steroid injections effectively treat patients with lumbar pain not associated with sciatica or radicular pain.

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

Facet Joint Injections

Diagnostic facet joint injection and/or facet nerve block (e.g., medial branch block) is proven and medically necessary to localize the source of pain to the facet joint in persons with spinal pain.

Therapeutic facet joint injection is unproven and not medically necessary for the treatment of chronic spinal pain. Clinical evidence about the very existence of facet joint syndrome is conflicting, and evidence from studies is inadequate regarding the superiority of periodic facet joint injections compared to placebo in relieving chronic spinal pain. (pain lasting more than 3 months).

Additional Information

Facet joint injection, as a **diagnostic procedure** prior to radiofrequency ablation, is not recommended in patients with:

- neurologic abnormalities
- more than one pain syndrome
- definitive clinical and/or imaging findings pointing to a specific diagnosis other than facet joint syndrome
- previous spinal surgery at the clinically suspected levels

APPLICABLE CODES

The Current Procedural Terminology (CPT[®]) codes and Healthcare Common Procedure Coding System (HCPCS) codes listed in this policy are for reference purposes only. Listing of a service code in this policy does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the enrollee specific benefit document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment. Other policies and coverage determination guidelines may apply. This list of codes may not be all inclusive.

CPT [®] Code (Unproven)	Description
0213T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; single level
0214T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; second level (List separately in addition to code for primary procedure)
0215T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)
0216T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; single level
0217T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; second level (List separately in addition to code for primary procedure)
0218T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)
0230T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level
0231T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure)

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CPT [®] Code (Facet)	Description
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)
64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)

CPT® Code (Facet)	Description
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)
64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)

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CPT® Code (Epidural)	Description
62311	Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)
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)

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Proven ICD-9 Code (Facet)	Description
720.9	Unspecified inflammatory spondylopathy
721.0	Cervical spondylosis without myelopathy
721.1	Cervical spondylosis with myelopathy
721.2	Thoracic spondylosis without myelopathy
721.3	Lumbosacral spondylosis without myelopathy
721.41	Spondylosis with myelopathy, thoracic region
721.42	Spondylosis with myelopathy, lumbar region
721.90	Spondylosis of unspecified site without mention of myelopathy
722.10	Displacement of lumbar intervertebral disc without myelopathy
722.81	Postlaminectomy syndrome, cervical region
722.82	Postlaminectomy syndrome, thoracic region
722.83	Postlaminectomy syndrome, lumbar region
733.13	Pathologic fracture of vertebrae
737.30	Scoliosis (and kyphoscoliosis), idiopathic
738.4	Acquired spondylolisthesis
805.00	Closed fracture of cervical vertebra, unspecified level without mention of spinal cord injury
805.01	Closed fracture of first cervical vertebra without mention of spinal cord injury
805.02	Closed fracture of second cervical vertebra without mention of spinal cord injury

Proven ICD-9 Code (Facet)	Description
805.03	Closed fracture of third cervical vertebra without mention of spinal cord injury
805.04	Closed fracture of fourth cervical vertebra without mention of spinal cord injury
805.05	Closed fracture of fifth cervical vertebra without mention of spinal cord injury
805.06	Closed fracture of sixth cervical vertebra without mention of spinal cord injury
805.07	Closed fracture of seventh cervical vertebra without mention of spinal cord injury
805.08	Closed fracture of multiple cervical vertebrae without mention of spinal cord injury
805.2	Closed fracture of dorsal (thoracic) vertebra without mention of spinal cord injury
805.4	Closed fracture of lumbar vertebra without mention of spinal cord injury
805.6	Sacrum and coccyx, closed
805.8	Unspecified, closed

Proven ICD-9 Code (Epidural)	Description
337.20	Unspecified reflex sympathetic dystrophy
337.22	Reflex sympathetic dystrophy of the lower limb
337.29	Reflex sympathetic dystrophy of other specified site
353.1	Lumbosacral plexus lesions
353.4	Lumbosacral root lesions, not elsewhere classified
355.0	Lesion of sciatic nerve
355.71	Causalgia of lower limb
355.79	Other mononeuritis of lower limb
355.8	Mononeuritis of lower limb, unspecified
355.9	Mononeuritis of unspecified site
721.3	Lumbosacral spondylosis without myelopathy
721.42	Spondylosis with myelopathy, lumbar region
722.10	Displacement of lumbar intervertebral disc without myelopathy
722.2	Displacement of intervertebral disc, site unspecified, without myelopathy
722.32	Schmorl's nodes, lumbar region
722.51	Degeneration of thoracic or thoracolumbar intervertebral disc
722.52	Degeneration of lumbar or lumbosacral intervertebral disc
722.73	Intervertebral lumbar disc disorder with myelopathy, lumbar region
722.83	Postlaminectomy syndrome, lumbar region
724.02	Spinal stenosis, lumbar region, without neurogenic claudication
724.03	Spinal stenosis, lumbar region, with neurogenic claudication
724.09	Spinal Stenosis, other than cervical, other
724.3	Sciatica
724.4	Thoracic or lumbosacral neuritis or radiculitis, unspecified
724.6	Disorders of sacrum
738.4	Acquired spondylolisthesis
805.4	Closed fracture of lumbar vertebra without mention of spinal cord injury
953.1	Injury to dorsal nerve root
953.2	Injury to lumbar nerve root

Proven ICD-9 Code (Epidural)	Description
953.3	Injury to sacral nerve root
953.5	Injury to lumbosacral plexus
956.0	Injury to sciatic nerve

ICD-10 Codes (Preview Draft)

In preparation for the transition from ICD-9 to ICD-10 medical coding on **October 1, 2015***, a sample listing of the ICD-10 CM and/or ICD-10 PCS codes associated with this policy has been provided below for your reference. This list of codes may not be all inclusive and will be updated to reflect any applicable revisions to the ICD-10 code set and/or clinical guidelines outlined in this policy. **The effective date for ICD-10 code set implementation is subject to change.*

ICD-10 Diagnosis Code Epidural (Effective 10/01/15)	Description
E08.41	Diabetes mellitus due to underlying condition with diabetic mononeuropathy
E09.41	Drug or chemical induced diabetes mellitus with neurological complications with diabetic mononeuropathy
E10.41	Type 1 diabetes mellitus with diabetic mononeuropathy
E11.41	Type 2 diabetes mellitus with diabetic mononeuropathy
E13.41	Other specified diabetes mellitus with diabetic mononeuropathy
G54.1	Lumbosacral plexus disorders
G54.4	Lumbosacral root disorders, not elsewhere classified
G57.00	Lesion of sciatic nerve, unspecified lower limb
G57.01	Lesion of sciatic nerve, right lower limb
G57.02	Lesion of sciatic nerve, left lower limb
G57.70	Causalgia of unspecified lower limb
G57.71	Causalgia of right lower limb
G57.72	Causalgia of left lower limb
G57.80	Other specified mononeuropathies of unspecified lower limb
G57.81	Other specified mononeuropathies of right lower limb
G57.82	Other specified mononeuropathies of left lower limb
G57.90	Unspecified mononeuropathy of unspecified lower limb
G57.91	Unspecified mononeuropathy of right lower limb
G57.92	Unspecified mononeuropathy of left lower limb
G58.8	Other specified mononeuropathies
G58.9	Mononeuropathy, unspecified
G59	Mononeuropathy in diseases classified elsewhere
G90.50	Complex regional pain syndrome I, unspecified
G90.521	Complex regional pain syndrome I of right lower limb
G90.522	Complex regional pain syndrome I of left lower limb
G90.523	Complex regional pain syndrome I of lower limb, bilateral
G90.529	Complex regional pain syndrome I of unspecified lower limb
G90.59	Complex regional pain syndrome I of other specified site
M43.00	Spondylolysis, site unspecified
M43.01	Spondylolysis, occipito-atlanto-axial region
M43.02	Spondylolysis, cervical region
M43.03	Spondylolysis, cervicothoracic region
M43.04	Spondylolysis, thoracic region
M43.05	Spondylolysis, thoracolumbar region
M43.06	Spondylolysis, lumbar region
M43.07	Spondylolysis, lumbosacral region

ICD-10 Diagnosis Code Epidural (Effective 10/01/15)	Description
M43.08	Spondylolysis, sacral and sacrococcygeal region
M43.09	Spondylolysis, multiple sites in spine
M43.10	Spondylolisthesis, site unspecified
M43.11	Spondylolisthesis, occipito-atlanto-axial region
M43.12	Spondylolisthesis, cervical region
M43.13	Spondylolisthesis, cervicothoracic region
M43.14	Spondylolisthesis, thoracic region
M43.15	Spondylolisthesis, thoracolumbar region
M43.16	Spondylolisthesis, lumbar region
M43.17	Spondylolisthesis, lumbosacral region
M43.18	Spondylolisthesis, sacral and sacrococcygeal region
M43.19	Spondylolisthesis, multiple sites in spine
M43.27	Fusion of spine, lumbosacral region
M43.28	Fusion of spine, sacral and sacrococcygeal region
M47.16	Other spondylosis with myelopathy, lumbar 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
M47.816	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
M47.896	Other spondylosis, lumbar region
M47.897	Other spondylosis, lumbosacral region
M47.898	Other spondylosis, sacral and sacrococcygeal region
M48.00	Spinal Stenosis, site unspecified
M48.06	Spinal stenosis, lumbar region
M48.07	Spinal stenosis, lumbosacral region
M48.08	Spinal stenosis, sacral and sacrococcygeal 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
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral 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
M51.36	Other intervertebral disc degeneration, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region
M51.46	Schmorl's nodes, lumbar region
M51.47	Schmorl's nodes, lumbosacral region
M51.9	Unspecified thoracic, thoracolumbar and lumbosacral intervertebral disc disorder
M53.2X7	Spinal instabilities, lumbosacral region
M53.2X8	Spinal instabilities, sacral and sacrococcygeal region
M53.3	Sacrococcygeal disorders, not elsewhere classified
M53.86	Other specified dorsopathies, lumbar region

ICD-10 Diagnosis Code Epidural (Effective 10/01/15)	Description
M53.87	Other specified dorsopathies, lumbosacral region
M53.88	Other specified dorsopathies, sacral and sacrococcygeal region
M54.14	Radiculopathy, thoracic 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
M99.23	Subluxation stenosis of neural canal of lumbar region
M99.24	Subluxation stenosis of neural canal of sacral region
M99.25	Subluxation stenosis of neural canal of pelvic region
M99.26	Subluxation stenosis of neural canal of lower extremity
M99.27	Subluxation stenosis of neural canal of upper extremity
M99.28	Subluxation stenosis of neural canal of rib cage
M99.29	Subluxation stenosis of neural canal of abdomen and other regions
M99.33	Osseous stenosis of neural canal of lumbar region
M99.34	Osseous stenosis of neural canal of sacral region
M99.35	Osseous stenosis of neural canal of pelvic region
M99.36	Osseous stenosis of neural canal of lower extremity
M99.37	Osseous stenosis of neural canal of upper extremity
M99.38	Osseous stenosis of neural canal of rib cage
M99.39	Osseous stenosis of neural canal of abdomen and other regions
M99.43	Connective tissue stenosis of neural canal of lumbar region
M99.44	Connective tissue stenosis of neural canal of sacral region
M99.45	Connective tissue stenosis of neural canal of pelvic region
M99.46	Connective tissue stenosis of neural canal of lower extremity
M99.47	Connective tissue stenosis of neural canal of upper extremity
M99.48	Connective tissue stenosis of neural canal of rib cage
M99.49	Connective tissue stenosis of neural canal of abdomen and other regions
M99.53	Intervertebral disc stenosis of neural canal of lumbar region
M99.54	Intervertebral disc stenosis of neural canal of sacral region
M99.55	Intervertebral disc stenosis of neural canal of pelvic region
M99.56	Intervertebral disc stenosis of neural canal of lower extremity
M99.57	Intervertebral disc stenosis of neural canal of upper extremity
M99.58	Intervertebral disc stenosis of neural canal of rib cage
M99.59	Intervertebral disc stenosis of neural canal of abdomen and other regions
M99.63	Osseous and subluxation stenosis of intervertebral foramina of lumbar region
M99.64	Osseous and subluxation stenosis of intervertebral foramina of sacral region
M99.65	Osseous and subluxation stenosis of intervertebral foramina of pelvic region
M99.66	Osseous and subluxation stenosis of intervertebral foramina of lower extremity

ICD-10 Diagnosis Code Epidural (Effective 10/01/15)	Description
M99.67	Osseous and spondylosis stenosis of intervertebral foramina of upper extremity
M99.68	Osseous and spondylosis stenosis of intervertebral foramina of rib cage
M99.69	Osseous and spondylosis stenosis of intervertebral foramina of abdomen and other regions
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
M99.75	Connective tissue and disc stenosis of intervertebral foramina of pelvic region
M99.76	Connective tissue and disc stenosis of intervertebral foramina of lower extremity
M99.77	Connective tissue and disc stenosis of intervertebral foramina of upper extremity
M99.78	Connective tissue and disc stenosis of intervertebral foramina of rib cage
M99.79	Connective tissue and disc stenosis of intervertebral foramina of abdomen and other regions
S24.2XXA	Injury of nerve root of thoracic spine, initial encounter
S32.000A	Wedge compression fracture of unspecified lumbar vertebra, initial encounter for closed fracture
S32.001A	Stable burst fracture of unspecified lumbar vertebra, initial encounter for closed fracture
S32.002A	Unstable burst fracture of unspecified lumbar vertebra, initial encounter for closed fracture
S32.008A	Other fracture of unspecified lumbar vertebra, initial encounter for closed fracture
S32.009A	Unspecified fracture of unspecified lumbar vertebra, initial encounter for closed fracture
S32.010A	Wedge compression fracture of first lumbar vertebra, initial encounter for closed fracture
S32.011A	Stable burst fracture of first lumbar vertebra, initial encounter for closed fracture
S32.012A	Unstable burst fracture of first lumbar vertebra, initial encounter for closed fracture
S32.018A	Other fracture of first lumbar vertebra, initial encounter for closed fracture
S32.019A	Unspecified fracture of first lumbar vertebra, initial encounter for closed fracture
S32.020A	Wedge compression fracture of second lumbar vertebra, initial encounter for closed fracture
S32.021A	Stable burst fracture of second lumbar vertebra, initial encounter for closed fracture
S32.022A	Unstable burst fracture of second lumbar vertebra, initial encounter for closed fracture
S32.028A	Other fracture of second lumbar vertebra, initial encounter for closed fracture
S32.029A	Unspecified fracture of second lumbar vertebra, initial encounter for closed fracture
S32.030A	Wedge compression fracture of third lumbar vertebra, initial

ICD-10 Diagnosis Code Epidural (Effective 10/01/15)	Description
	encounter for closed fracture
S32.031A	Stable burst fracture of third lumbar vertebra, initial encounter for closed fracture
S32.032A	Unstable burst fracture of third lumbar vertebra, initial encounter for closed fracture
S32.038A	Other fracture of third lumbar vertebra, initial encounter for closed fracture
S32.039A	Unspecified fracture of third lumbar vertebra, initial encounter for closed fracture
S32.040A	Wedge compression fracture of fourth lumbar vertebra, initial encounter for closed fracture
S32.041A	Stable burst fracture of fourth lumbar vertebra, initial encounter for closed fracture
S32.042A	Unstable burst fracture of fourth lumbar vertebra, initial encounter for closed fracture
S32.048A	Other fracture of fourth lumbar vertebra, initial encounter for closed fracture
S32.049A	Unspecified fracture of fourth lumbar vertebra, initial encounter for closed fracture
S32.050A	Wedge compression fracture of fifth lumbar vertebra, initial encounter for closed fracture
S32.051A	Stable burst fracture of fifth lumbar vertebra, initial encounter for closed fracture
S32.052A	Unstable burst fracture of fifth lumbar vertebra, initial encounter for closed fracture
S32.058A	Other fracture of fifth lumbar vertebra, initial encounter for closed fracture
S32.059A	Unspecified fracture of fifth lumbar vertebra, initial encounter for closed fracture
S34.21XA	Injury of nerve root of lumbar spine, initial encounter
S34.22XA	Injury of nerve root of sacral spine, initial encounter
S34.4XXA	Injury of lumbosacral plexus, initial encounter
S74.00XA	Injury of sciatic nerve at hip and thigh level, unspecified leg, initial encounter
S74.01XA	Injury of sciatic nerve at hip and thigh level, right leg, initial encounter
S74.02XA	Injury of sciatic nerve at hip and thigh level, left leg, initial encounter

ICD-10 Diagnosis Code Facet (Effective 10/01/15)	Description
M41.112	Juvenile idiopathic scoliosis, cervical region
M41.113	Juvenile idiopathic scoliosis, cervicothoracic region
M41.114	Juvenile idiopathic scoliosis, thoracic region
M41.115	Juvenile idiopathic scoliosis, thoracolumbar region
M41.116	Juvenile idiopathic scoliosis, lumbar region
M41.117	Juvenile idiopathic scoliosis, lumbosacral region
M41.119	Juvenile idiopathic scoliosis, site unspecified
M41.122	Adolescent idiopathic scoliosis, cervical region
M41.123	Adolescent idiopathic scoliosis, cervicothoracic region
M41.124	Adolescent idiopathic scoliosis, thoracic region

ICD-10 Diagnosis Code Facet (Effective 10/01/15)	Description
M41.125	Adolescent idiopathic scoliosis, thoracolumbar region
M41.126	Adolescent idiopathic scoliosis, lumbar region
M41.127	Adolescent idiopathic scoliosis, lumbosacral region
M41.129	Adolescent idiopathic scoliosis, site unspecified
M41.20	Other idiopathic scoliosis, site unspecified
M41.22	Other idiopathic scoliosis, cervical region
M41.23	Other idiopathic scoliosis, cervicothoracic region
M41.24	Other idiopathic scoliosis, thoracic region
M41.25	Other idiopathic scoliosis, thoracolumbar region
M41.26	Other idiopathic scoliosis, lumbar region
M41.27	Other idiopathic scoliosis, lumbosacral region
M43.00	Spondylolysis, site unspecified
M43.01	Spondylolysis, occipito-atlanto-axial region
M43.02	Spondylolysis, cervical region
M43.03	Spondylolysis, cervicothoracic region
M43.04	Spondylolysis, thoracic region
M43.05	Spondylolysis, thoracolumbar region
M43.06	Spondylolysis, lumbar region
M43.07	Spondylolysis, lumbosacral region
M43.08	Spondylolysis, sacral and sacrococcygeal region
M43.09	Spondylolysis, multiple sites in spine
M43.10	Spondylolisthesis, site unspecified
M43.11	Spondylolisthesis, occipito-atlanto-axial region
M43.12	Spondylolisthesis, cervical region
M43.13	Spondylolisthesis, cervicothoracic region
M43.14	Spondylolisthesis, thoracic region
M43.15	Spondylolisthesis, thoracolumbar region
M43.16	Spondylolisthesis, lumbar region
M43.17	Spondylolisthesis, lumbosacral region
M43.18	Spondylolisthesis, sacral and sacrococcygeal region
M43.19	Spondylolisthesis, multiple sites in spine
M46.90	Unspecified inflammatory spondylopathy, site unspecified
M46.91	Unspecified inflammatory spondylopathy, occipito-atlanto-axial region
M46.92	Unspecified inflammatory spondylopathy, cervical region
M46.93	Unspecified inflammatory spondylopathy, cervicothoracic region
M46.94	Unspecified inflammatory spondylopathy, thoracic region
M46.95	Unspecified inflammatory spondylopathy, thoracolumbar region
M46.96	Unspecified inflammatory spondylopathy, lumbar region
M46.97	Unspecified inflammatory spondylopathy, lumbosacral region
M46.98	Unspecified inflammatory spondylopathy, sacral and sacrococcygeal region
M46.99	Unspecified inflammatory spondylopathy, multiple sites in spine
M47.011	Anterior spinal artery compression syndromes, occipito-atlanto-axial region
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

ICD-10 Diagnosis Code Facet (Effective 10/01/15)	Description
M47.019	Anterior spinal artery compression syndromes, site unspecified
M47.11	Other spondylosis with myelopathy, occipito-atlanto-axial region
M47.12	Other spondylosis with myelopathy, cervical region
M47.13	Other spondylosis with myelopathy, cervicothoracic region
M47.14	Other spondylosis with myelopathy, thoracic region
M47.15	Other spondylosis with myelopathy, thoracolumbar region
M47.16	Other spondylosis with myelopathy, lumbar region
M47.20	Other spondylosis with radiculopathy, site unspecified
M47.21	Other spondylosis with radiculopathy, occipito-atlanto-axial 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
M47.811	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial 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
M47.819	Spondylosis without myelopathy or radiculopathy, site unspecified
M47.891	Other spondylosis, occipito-atlanto-axial 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
M47.899	Other spondylosis, site unspecified
M47.9	Spondylosis, unspecified
M48.50XA	Collapsed vertebra, not elsewhere classified, site unspecified, initial encounter for fracture
M48.51XA	Collapsed vertebra, not elsewhere classified, occipito-atlanto-axial region, initial encounter for fracture
M48.52XA	Collapsed vertebra, not elsewhere classified, cervical region, initial encounter for fracture
M48.53XA	Collapsed vertebra, not elsewhere classified, cervicothoracic region, initial encounter for fracture
M48.54XA	Collapsed vertebra, not elsewhere classified, thoracic region, initial encounter for fracture

ICD-10 Diagnosis Code Facet (Effective 10/01/15)	Description
M48.55XA	Collapsed vertebra, not elsewhere classified, thoracolumbar region, initial encounter for fracture
M48.56XA	Collapsed vertebra, not elsewhere classified, lumbar region, initial encounter for fracture
M48.57XA	Collapsed vertebra, not elsewhere classified, lumbosacral region, initial encounter for fracture
M48.58XA	Collapsed vertebra, not elsewhere classified, sacral and sacrococcygeal region, initial encounter for fracture
M51.26	Other intervertebral disc displacement, lumbar region
M51.27	Other intervertebral disc displacement, lumbosacral region
M80.08XA	Age-related osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture
M80.88XA	Other osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture
M84.48XA	Pathological fracture, other site, initial encounter for fracture
M84.58XA	Pathological fracture in neoplastic disease, other specified site, initial encounter for fracture
M84.68XA	Pathological fracture in other disease, other site, initial encounter for fracture
M96.1	Postlaminectomy syndrome, not elsewhere classified
S12.000A	Unspecified displaced fracture of first cervical vertebra, initial encounter for closed fracture
S12.001A	Unspecified nondisplaced fracture of first cervical vertebra, initial encounter for closed fracture
S12.01XA	Stable burst fracture of first cervical vertebra, initial encounter for closed fracture
S12.02XA	Unstable burst fracture of first cervical vertebra, initial encounter for closed fracture
S12.030A	Displaced posterior arch fracture of first cervical vertebra, initial encounter for closed fracture
S12.031A	Nondisplaced posterior arch fracture of first cervical vertebra, initial encounter for closed fracture
S12.040A	Displaced lateral mass fracture of first cervical vertebra, initial encounter for closed fracture
S12.041A	Nondisplaced lateral mass fracture of first cervical vertebra, initial encounter for closed fracture
S12.090A	Other displaced fracture of first cervical vertebra, initial encounter for closed fracture
S12.091A	Other nondisplaced fracture of first cervical vertebra, initial encounter for closed fracture
S12.100A	Unspecified displaced fracture of second cervical vertebra, initial encounter for closed fracture
S12.101A	Unspecified nondisplaced fracture of second cervical vertebra, initial encounter for closed fracture
S12.110A	Anterior displaced Type II dens fracture, initial encounter for closed fracture
S12.111A	Posterior displaced Type II dens fracture, initial encounter for closed fracture
S12.112A	Nondisplaced Type II dens fracture, initial encounter for closed fracture
S12.120A	Other displaced dens fracture, initial encounter for closed fracture
S12.121A	Other nondisplaced dens fracture, initial encounter for closed

ICD-10 Diagnosis Code Facet (Effective 10/01/15)	Description
	fracture
S12.130A	Unspecified traumatic displaced spondylolisthesis of second cervical vertebra, initial encounter for closed fracture
S12.131A	Unspecified traumatic nondisplaced spondylolisthesis of second cervical vertebra, initial encounter for closed fracture
S12.14XA	Type III traumatic spondylolisthesis of second cervical vertebra, initial encounter for closed fracture
S12.150A	Other traumatic displaced spondylolisthesis of second cervical vertebra, initial encounter for closed fracture
S12.151A	Other traumatic nondisplaced spondylolisthesis of second cervical vertebra, initial encounter for closed fracture
S12.190A	Other displaced fracture of second cervical vertebra, initial encounter for closed fracture
S12.191A	Other nondisplaced fracture of second cervical vertebra, initial encounter for closed fracture
S12.200A	Unspecified displaced fracture of third cervical vertebra, initial encounter for closed fracture
S12.201A	Unspecified nondisplaced fracture of third cervical vertebra, initial encounter for closed fracture
S12.230A	Unspecified traumatic displaced spondylolisthesis of third cervical vertebra, initial encounter for closed fracture
S12.231A	Unspecified traumatic nondisplaced spondylolisthesis of third cervical vertebra, initial encounter for closed fracture
S12.24XA	Type III traumatic spondylolisthesis of third cervical vertebra, initial encounter for closed fracture
S12.250A	Other traumatic displaced spondylolisthesis of third cervical vertebra, initial encounter for closed fracture
S12.251A	Other traumatic nondisplaced spondylolisthesis of third cervical vertebra, initial encounter for closed fracture
S12.290A	Other displaced fracture of third cervical vertebra, initial encounter for closed fracture
S12.291A	Other nondisplaced fracture of third cervical vertebra, initial encounter for closed fracture
S12.300A	Unspecified displaced fracture of fourth cervical vertebra, initial encounter for closed fracture
S12.301A	Unspecified nondisplaced fracture of fourth cervical vertebra, initial encounter for closed fracture
S12.330A	Unspecified traumatic displaced spondylolisthesis of fourth cervical vertebra, initial encounter for closed fracture
S12.331A	Unspecified traumatic nondisplaced spondylolisthesis of fourth cervical vertebra, initial encounter for closed fracture
S12.34XA	Type III traumatic spondylolisthesis of fourth cervical vertebra, initial encounter for closed fracture
S12.350A	Other traumatic displaced spondylolisthesis of fourth cervical vertebra, initial encounter for closed fracture
S12.351A	Other traumatic nondisplaced spondylolisthesis of fourth cervical vertebra, initial encounter for closed fracture
S12.390A	Other displaced fracture of fourth cervical vertebra, initial encounter for closed fracture
S12.391A	Other nondisplaced fracture of fourth cervical vertebra, initial encounter for closed fracture
S12.400A	Unspecified displaced fracture of fifth cervical vertebra, initial

ICD-10 Diagnosis Code Facet (Effective 10/01/15)	Description
	encounter for closed fracture
S12.401A	Unspecified nondisplaced fracture of fifth cervical vertebra, initial encounter for closed fracture
S12.430A	Unspecified traumatic displaced spondylolisthesis of fifth cervical vertebra, initial encounter for closed fracture
S12.431A	Unspecified traumatic nondisplaced spondylolisthesis of fifth cervical vertebra, initial encounter for closed fracture
S12.44XA	Type III traumatic spondylolisthesis of fifth cervical vertebra, initial encounter for closed fracture
S12.450A	Other traumatic displaced spondylolisthesis of fifth cervical vertebra, initial encounter for closed fracture
S12.451A	Other traumatic nondisplaced spondylolisthesis of fifth cervical vertebra, initial encounter for closed fracture
S12.490A	Other displaced fracture of fifth cervical vertebra, initial encounter for closed fracture
S12.491A	Other nondisplaced fracture of fifth cervical vertebra, initial encounter for closed fracture
S12.500A	Unspecified displaced fracture of sixth cervical vertebra, initial encounter for closed fracture
S12.501A	Unspecified nondisplaced fracture of sixth cervical vertebra, initial encounter for closed fracture
S12.530A	Unspecified traumatic displaced spondylolisthesis of sixth cervical vertebra, initial encounter for closed fracture
S12.531A	Unspecified traumatic nondisplaced spondylolisthesis of sixth cervical vertebra, initial encounter for closed fracture
S12.54XA	Type III traumatic spondylolisthesis of sixth cervical vertebra, initial encounter for closed fracture
S12.550A	Other traumatic displaced spondylolisthesis of sixth cervical vertebra, initial encounter for closed fracture
S12.551A	Other traumatic nondisplaced spondylolisthesis of sixth cervical vertebra, initial encounter for closed fracture
S12.590A	Other displaced fracture of sixth cervical vertebra, initial encounter for closed fracture
S12.591A	Other nondisplaced fracture of sixth cervical vertebra, initial encounter for closed fracture
S12.600A	Unspecified displaced fracture of seventh cervical vertebra, initial encounter for closed fracture
S12.601A	Unspecified nondisplaced fracture of seventh cervical vertebra, initial encounter for closed fracture
S12.630A	Unspecified traumatic displaced spondylolisthesis of seventh cervical vertebra, initial encounter for closed fracture
S12.631A	Unspecified traumatic nondisplaced spondylolisthesis of seventh cervical vertebra, initial encounter for closed fracture
S12.64XA	Type III traumatic spondylolisthesis of seventh cervical vertebra, initial encounter for closed fracture
S12.650A	Other traumatic displaced spondylolisthesis of seventh cervical vertebra, initial encounter for closed fracture
S12.651A	Other traumatic nondisplaced spondylolisthesis of seventh cervical vertebra, initial encounter for closed fracture
S12.690A	Other displaced fracture of seventh cervical vertebra, initial encounter for closed fracture
S12.691A	Other nondisplaced fracture of seventh cervical vertebra, initial

ICD-10 Diagnosis Code Facet (Effective 10/01/15)	Description
S12.9XXA	Fracture of neck, unspecified, initial encounter

DESCRIPTION OF SERVICES

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

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

Epidural steroid injection (ESI) is a nonsurgical treatment for managing low back pain and sciatica caused by disc herniation or degenerative changes in the vertebrae. An epidural steroid injection is an injection of long lasting steroid in the epidural space; that is the area which surrounds the spinal cord and the nerves coming out of it. The goal of ESI is to relieve pain, improve function, and reduce the need for surgical intervention. (Hayes, 2007)

Chronic nonmalignant back pain is defined as pain lasting 3 - 6 months or more that is not due to cancer.

CLINICAL EVIDENCE

Ultrasound Guidance

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

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

The clinical evidence was reviewed on January 14, 2014 with no additional information identified that would change the unproven and not medically necessary conclusions.

Facet Injections

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

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

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

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

Carette et al. (1991) conducted a well-designed, randomized controlled trial that included patients with low back pain of at least 6 months duration. Patients were assigned to receive either facet joint injection with methylprednisolone acetate (n=49) or saline (n=48). At 1 and 3 months after the injections, the 2 groups did not differ on measures of pain relief, functional status, or back

flexion. At 6 months, those who received corticosteroid injections reported more improvement, less pain, and less physical disability, but this might have been explained in part by more use of other concurrent interventions.

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

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

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

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

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

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

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

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

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

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

Professional Societies

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

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

The clinical evidence was reviewed on January 14, 2014 with no additional information identified that would change the conclusions noted within the coverage rationale.

Epidural Steroid Injections

Novak and Nemeth (2008) conducted a literature review to evaluate the effect of repeat epidural injections and/or the timing of injections to treat low back pain. Of the 91 articles identified, 15 were included in the review. The authors found little evidence to suggest that repeat epidural steroid injections are beneficial. The authors also found little evidence to suggest guidelines for frequency and timing of epidural steroid injections. The authors suggest that further studies with at least a 1 year follow-up are necessary to evaluate the timing and number of repeat injections.

Abdi et al. (2007) conducted a systemic review of published trials and abstracts of scientific meetings, published between January 1966 and October 2006, to determine the efficacy and safety of ESIs. The primary outcome measure was pain relief. Other outcome measures were functional improvement, improvement of psychological status, and return to work. They identified 11 randomized trials of lumbar interlaminar ESI. Of these studies, 8 had favorable results for short-term (< 6 weeks) relief and 1 was positive for long-term (6 weeks) relief. The level of evidence for interlaminar ESIs was considered strong for short-term pain relief and limited for long-term pain relief. There were 7 randomized trials of lumbar transforaminal ESI (TFESI), 5 of which had favorable results for both short- and long-term pain relief. The level of evidence for TFESI was considered strong for short-term pain relief and moderate for long-term pain relief. Of the 8 randomized trials of caudal ESIs, 5 had favorable results for short-term pain relief and 4 had favorable results for long-term pain relief. The level of evidence for caudal epidural injections was considered strong for short-term relief and moderate for long-term relief.

Manchicanti et al. (2010b) conducted a double-blind randomized controlled trial of interlaminar epidural steroid injections, with and without steroids, in managing chronic pain of lumbar disc herniation or radiculitis. Seventy patients were equally randomized to receive either a local anesthetic only (group I) or a local anesthetic mixed with a steroid (group II). Outcomes were measured at baseline, 3, 6, and 12 months post-treatment with the Numeric Rating Scale (NRS), the Oswestry Disability Index 2.0 (ODI), employment status, and opioid intake. Significant pain

relief ($\geq 50\%$) was seen at 12 months in 74% of patients in group I and 86% in group II, and 69% and 83% in ODI scores respectively. Patients in group II also had more improvement in functional status at 12 months (83% vs. 69%) and required less opioid intake.

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

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

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

Buttermann (2004) conducted a randomized comparative study of epidural betamethasone injections or discectomy for the treatment of herniated nucleus pulposus. Initially the patients were treated with either epidural injections of betamethasone (n=50) or discectomy (n=50). Patients who failed to obtain relief with steroid injections were entered into a crossover group (n=27) and treated with discectomy. The discectomy group had earlier motor recovery than the steroid group; however, there were no other significant differences between groups. The results suggested that epidural betamethasone injections were not as effective as discectomy. However, steroid injections were effective for up to 3 years in nearly half of the patients who had not responded to conservative treatment.

Khot et al. (2004) performed a single-blind, randomized, placebo-controlled study of epidural steroid injection for patients with low back pain of discogenic origin. In this study, 60 patients were randomly assigned to receive epidural methylprednisolone, while 60 patients received a placebo epidural injection. After 1 year, there was no difference in outcome between the treatment and placebo groups.

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

In one of the largest recent double-blind, randomized studies, Price et al. (2005) evaluated the effect of epidural steroid injection on 228 patients with either acute or chronic sciatica. Patients received either epidural steroid or placebo injection, up to 3 injections, and were then evaluated periodically for a 12-month period. At 3 weeks after injection, more patients in the steroid group

reported reduction in pain and showed improvement in the Oswestry Disability Index score than did patients in the placebo group; however, at all other follow-up times, there were no significant differences in any outcomes between the treatment and control group. This suggested that any effect of epidural steroid was transient.

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

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

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

Professional Societies

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

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

American Society of Interventional Pain Physicians (ASIPP): Evidence-Based Practice Guidelines in the Management of Chronic Spinal Pain state that there is no consensus among

interventional pain management specialists regarding the type, dosage, frequency, total number of injections, or other interventions. The frequency and total number of injections have been considered important issues, although controversial and poorly addressed. The authors recommend that administration be based solely on patient response, safety profile of the drug, experience of the patient, and pharmacological and chemical properties, such as duration of action and suppression of adrenals. (Manchicanti, et al., 2009)

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

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

North American Spine Society (NASS): The NASS has developed clinical guidelines that address the diagnosis and treatment of degenerative lumbar spinal stenosis (NASS, (Updated 2011.) The guidelines state that while there is evidence that nonfluoroscopically guided interlaminar and single radiographically guided transforaminal ESIs can result in short-term symptom relief in patients with neurogenic claudication or radiculopathy, there is conflicting evidence concerning long-term efficacy. The guidelines also note that there is some evidence that a multiple injection regimen of radiographically guided transforaminal ESIs or caudal injections can produce long-term relief of pain in patients with radiculopathy or neurogenic intermittent claudication from lumbar spinal stenosis. However, the evidence is of relatively poor quality, and therefore no strong recommendation in support of this therapy was made.

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

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

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

Additional information may be obtained from the U.S. Food and Drug Administration [Website] - Center for Drug Evaluation and Research (CDER) at: <http://www.fda.gov/cder/drug/default.htm>. Accessed January 14, 2014

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Medicare does not have a National Coverage Determination (NCD) for steroid or facet injections used for the treatment of spinal pain. Local Coverage Determinations (LCDs) do exist. Refer to the LCDs for: [Epidural and Transforaminal Injections](#), [Epidural, Facet Joint Injections](#), [Nerve Blockade somatic selective nerve root and epidural](#), [Non Covered Services](#), [Pain Management](#), [Paravertebral Facet Joint Block and Facet Joint Denervation](#), [Paravertebral Facet Joint Block](#), [Paravertebral facet joint nerve blockade](#), [Services that are not reasonable and necessary](#), [Surgery: Injections of the spinal canal](#), [Surgery: Lumbar Facet Blockade](#) and [Transforaminal Epidural Paravertebral Facet and Sacroiliac Joint Injections](#)

(Accessed January 15, 2014)

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POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
06/01/2014	<ul style="list-style-type: none"> • Reorganized policy content • Added benefit considerations language for <i>Essential Health Benefits for Individual and Small Group</i> plans to indicate: <ul style="list-style-type: none"> ○ For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-

	<p>grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits (“EHBs”)</p> <ul style="list-style-type: none"> ○ Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs; however, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans ○ The determination of which benefits constitute EHBs is made on a state by state basis; as such, when using this guideline, it is important to refer to the enrollee’s specific plan document to determine benefit coverage ● Updated coverage rationale; added language to indicate if service is “medically necessary” or “not medically necessary” to applicable proven/unproven statement ● Updated list of applicable ICD-9 codes: <ul style="list-style-type: none"> ○ Added 722.32 ○ Removed 353.8 ● Revised list of applicable ICD-10 codes (preview draft effective 10/01/15): <ul style="list-style-type: none"> ○ Changed tentative effective date of ICD-10 code set implementation from “10/01/14” to “10/01/15” ○ Epidural: <ul style="list-style-type: none"> ▪ Added M43.16, M48.00, M51.46, M51.47 and M51.9 ▪ Removed G54.8, G55, M46.90 - M46.99, M47.011 - M47.014, M47.016, M47.019, M47.021, M47.022, M47.029, M47.11 - M47.13, M47.20 - M47.25, M47.811 - M47.815, M47.819, M47.891 - M47.895, M47.899, M47.9, M48.50XA - M48.58XA, S32.10XA, S32.110A - S32.112A, S32.119A - S32.122A, S32.129A - S32.132A, S32.139A, S32.14XA - S32.17XA, S32.19XA and S32.2XXA ○ Facet: <ul style="list-style-type: none"> ▪ Removed M34.4XXA, M47.021, M47.022, M47.029, M47.17, M47.18, S22.000A - S22.002A, S22.008A - S22.012A, S22.018A - S22.022A, S22.028A - S22.032A, S22.038A - S22.042A, S22.048A - S22.052A, S22.058A - S22.062A, S22.068A - S22.072A, S22.078A - S22.082A, S22.088A, S22.089A, S32.000A - S32.002A, S32.008A - S32.012A, S32.018A - S32.022A, S32.028A - S32.032A, S32.038A - S32.042A, S32.048A - S32.052A, S32.058A, S32.059A, S32.10XA, S32.110A - S32.112A, S32.119A - S32.122A, S32.129A - S32.132A, S32.139A, S32.14XA - S32.17XA, S32.19XA and S32.2XXA ● Updated supporting information to reflect the most current clinical evidence, CMS information and references ● Archived previous policy version 2013T0004S
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