REIMBURSEMENT POLICY STATEMENT
GEORGIA MEDICAID

Policy Name		Policy Number	Effective Date
Epidural Steroid Injections		PY-1054	12/01/2020-05/31/2021
Policy Type			
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement Policy Statement: Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

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A. Subject

Epidural Steroid Injections

B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

Nearly 84% of adults experience back pain during their lifetime. Long term outcomes are largely favorable for most patients, but a small percentage of patient's symptoms are categorized as chronic. Chronic pain is defined by the International Association for the Study of Pain as: "pain that persists beyond normal tissue healing time, which is assumed to be three months".

Interventional procedures for management of acute and chronic pain are part of a comprehensive pain management care plan that incorporates conservative treatment in a multimodality approach. Multidisciplinary treatments include promoting patient self-management and aim to reduce the impact of pain on a patient's daily life, even if the pain cannot be relieved completely. Interventional procedures for the management of pain unresponsive to conservative treatment should be provided only by physicians qualified to deliver these health services.

C. Definitions

- **Epidural Steroid Injections** - for persistent or chronic radicular pain involve injection of corticosteroid, local anesthetic, opioid, or combination medication into the epidural space, requiring fluoroscopic imaging and injection of an appropriate agent to achieve a selective reproducible blockage of a specific nerve root. Anatomic locations for epidural injections may involve the interlaminar space at the midline between vertebral bodies, caudal epidural injections or transforaminal epidural injections. Epidural injections may be diagnostic for localizing and determining the cause of radiating pain and providing short term pain relief.

D. Policy

I. Epidural Steroid Injections
   A. A prior authorization (PA) is required for each epidural injection for pain management by the same or any physician, excluding labor and delivery in

childbirth and for post surgical pain. Documentation, including dates of service, for conservative therapies are not required for PA, but must be available upon request.

B. The maximum epidurals of all types of epidural injections a member can receive in a rolling twelve (12) months is a total of six (6), regardless of the number of levels involved.
   1. Repeat injections sooner than three (3) weeks may not reach pharmacodynamic effect of the corticosteroid and will not be covered.
   2. Requests for repeat injections beyond three (3) weeks without documentation of suitable pain score reduction and functional improvements, or other documented rationale as described in this policy will not be covered.

C. For Interlaminar or Caudal Epidural Injections
   1. More than one (1) epidural injection per treatment date will not be authorized.
   2. Bilateral injections and modifiers will not be recognized and coverage will be denied.

D. For Transforaminal Epidurals or Selective Nerve Root Blocks (SNRB's)
   1. Transforaminal Epidurals provided to more than two (2) vertebral levels per treatment date, whether unilateral or bilateral, will not be authorized and will not be covered.
   2. Prior authorization is required for treatment sessions per each spine region.

E. Repeat Therapeutic Injections
   1. Epidural injections may be repeated only when considered medically necessary and the following criteria is met:
      a. There must be at least 21 days between injections;
      b. No more than three (3) procedures in a twelve (12)-week period of time per region;
      c. Prior injection had a positive response by significantly decreasing pain;
      d. The patient continues to have ongoing pain or documented functional disability (≥ 6 on a scale of 0 to 10); and
      e. The patient is actively engaged in other forms of conservative non-operative treatment.
         (1) Unless pain prevents the patient from participating in conservative therapy, which must be documented in the contemporaneous medical record.

F. Real-time image guidance and any injection of contrast are inclusive components of epidural injections and are not compensated for separately or unbundled for coverage.

G. Ultrasound guidance for epidural injections is inappropriate.

H. Conscious sedation, if required for co-morbidities or patient/physician preference, may be provided without prior authorization but services will be considered part of the procedure and are not eligible for additional reimbursement if administered by a second provider.
   1. Coverage for monitored anesthesia will not be provided as not medically necessary.
   2. When anesthesia services are provided they must be delivered by CareSource credentialed providers, including anesthesiologists and/or CRNAs.

E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

- **The following list(s) of codes is provided as a reference. This list may not be all inclusive and is subject to updates.**

Epidural	Description
62320	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
62321	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)
62322	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
62323	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); with imaging 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)

F. Related Policies/Rules

Epidural Steroid Injections GA MCD MM-0217

G. Review/Revision History

	DATE	ACTION
Date Issued	12/11/2019	
Date Revised	06/10/2020	Annual Update: No changes
Date Effective	12/01/2020	
Date Archived	05/31/2021	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy

H. References

1. Georgia Department of Community Health Fee Schedules. Retrieved on May 20, 2020 from mmis.georgia.gov

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.

GA-MED-P-165374 Date Issued 12/11/2019 DCH Approved 07/27/2020