Local Coverage Determination (LCD) for Epidural (L29165)

Contractor Information

Contractor Name
First Coast Service Options, Inc.

Contractor Number
09102

Contractor Type
MAC - Part B

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LCD Information

Document Information

LCD ID Number
L29165

LCD Title
Epidural

Contractor's Determination Number
62310

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Primary Geographic Jurisdiction
Florida

Oversight Region
Region IV

Original Determination Effective Date
For services performed on or after 02/02/2009

Original Determination Ending Date

Revision Effective Date
For services performed on or after 01/01/2012

Revision Ending Date

CMS National Coverage Policy
Language quoted from CMS National Coverage Determination (NCDs) and coverage provisions in interpretive manuals are italicized throughout the Local Coverage Determination (LCD). NCDs and coverage provisions in interpretive manuals are not subject to the LCD Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See §1869(f)(1)(A)(i) of the Social Security Act.
Unless otherwise specified, italicized text represent quotation from one or more of the following CMS sources:

Change Request 7121, Transmittal 2037, dated August 27, 2010

Indications and Limitations of Coverage and/or Medical Necessity
Epidural injections are used for the treatment of multiple different conditions in chronic and acute pain. Epidural injections may be used for therapeutic and/or diagnostic purposes. There are multiple approaches to epidural injections including caudal, translaminar, and transforaminal. These different approaches are used for different but specific indications. (In general it is felt that the closer the injection can be placed to the pathology the more likely to achieve a beneficial response). Correct placement is best confirmed by using fluoroscopic guidance and injection of contrast.

Medicare will consider Epidural injections and/or infusions medically reasonable and necessary for the following conditions:

1. Management of pain caused by intervertebral disc disease with or without myelopathy.

2. Management of pain caused by spinal stenosis.

3. Management of intractable radicular pain due to postlaminectomy syndrome/failed back syndrome.

4. Management of intractable pain due to complex regional pain syndrome.

5. Management of intractable pain due to post herpetic neuralgia and acute herpes zoster.

6. Management of intractable pain due to traumatic neuropathy of the spinal nerve roots.

7. Management of intractable and severe pain secondary to neuropathy from other causes (e.g., diabetic or metabolic).

8. Management of severe, intractable pain in patients with advanced stages of cancer with estimated life expectancy of 4 months or less.

9. Management of pain caused by radiculitis (inflammation of the nerve roots).

Low back pain may also be produced by “Myofascial Pain Syndrome” in which case there is not nerve root pathology and epidural injections are not reasonable and necessary. If there is a doubt in the differential diagnosis, the diagnosis of radiculopathy can be confirmed by an EMG/nerve conduction/small fiber testing or appropriate radiological study. Degenerative Disk Disease without root compression has been shown to be a significant cause of low back and/or radicular pain; some patients will respond to Epidural Steroid Injection in this situation.

Epidural injections, regardless of the approach used, should be performed under fluoroscopic or CT-guided imaging. Therefore, injections for chronic pain performed without imaging guidance are considered not medically reasonable or necessary.

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Coding Information

Bill Type Codes:
Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

Revenue Codes:
Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

99999	Not Applicable

CPT/HCPCS Codes
GroupName

For Single Injection

62310	INJECTION(S), OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S) (INCLUDING ANESTHETIC, ANTISPASMODIC, OPIOID, STEROID, OTHER SOLUTION), NOT INCLUDING NEUROLYTIC SUBSTANCES, INCLUDING NEEDLE OR CATHETER PLACEMENT, INCLUDES CONTRAST FOR LOCALIZATION WHEN PERFORMED, EPIDURAL OR SUBARACHNOID; CERVICAL OR THORACIC
62311	INJECTION(S), OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S) (INCLUDING ANESTHETIC, ANTISPASMODIC, OPIOID, STEROID, OTHER SOLUTION), NOT INCLUDING NEUROLYTIC SUBSTANCES, INCLUDING NEEDLE OR CATHETER PLACEMENT, INCLUDES CONTRAST FOR LOCALIZATION WHEN PERFORMED, EPIDURAL OR SUBARACHNOID; LUMBAR OR SACRAL (CAUDAL)

GroupName

For Transforaminal Epidural Injections

64479	INJECTION, ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); CERVICAL OR THORACIC, SINGLE LEVEL
64480	INJECTION, 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, ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); LUMBAR OR SACRAL, SINGLE LEVEL
64484	

	INJECTION, 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-9 Codes that Support Medical Necessity

053.10	HERPES ZOSTER WITH UNSPECIFIED NERVOUS SYSTEM COMPLICATION
053.13	POSTHERPETIC POLYNEUROPATHY
053.14	HERPES ZOSTER MYELITIS
053.19	HERPES ZOSTER WITH OTHER NERVOUS SYSTEM COMPLICATIONS
160.0 - 165.9	MALIGNANT NEOPLASM OF NASAL CAVITIES - MALIGNANT NEOPLASM OF ILL-DEFINED SITES WITHIN THE RESPIRATORY SYSTEM
170.0 - 176.9	MALIGNANT NEOPLASM OF BONES OF SKULL AND FACE EXCEPT MANDIBLE - KAPOSI'S SARCOMA UNSPECIFIED SITE
179 - 189.9	MALIGNANT NEOPLASM OF UTERUS-PART UNS - MALIGNANT NEOPLASM OF URINARY ORGAN SITE UNSPECIFIED
190.0 - 199.2	MALIGNANT NEOPLASM OF EYEBALL EXCEPT CONJUNCTIVA CORNEA RETINA AND CHOROID - MALIGNANT NEOPLASM ASSOCIATED WITH TRANSPLANT ORGAN
200.00 - 208.92	RETICULOSARCOMA UNSPECIFIED SITE - UNSPECIFIED LEUKEMIA, IN RELAPSE
209.00 - 209.69	MALIGNANT CARCINOID TUMOR OF THE SMALL INTESTINE, UNSPECIFIED PORTION - BENIGN CARCINOID TUMOR OF OTHER SITES
209.70 - 209.79	SECONDARY NEUROENDOCRINE TUMOR, UNSPECIFIED SITE - SECONDARY NEUROENDOCRINE TUMOR OF OTHER SITES
210.0 - 229.9	BENIGN NEOPLASM OF LIP - BENIGN NEOPLASM OF UNSPECIFIED SITE
230.0 - 234.9	CARCINOMA IN SITU OF LIP ORAL CAVITY AND PHARYNX - CARCINOMA IN SITU SITE UNSPECIFIED
235.0 - 238.9	NEOPLASM OF UNCERTAIN BEHAVIOR OF MAJOR SALIVARY GLANDS - NEOPLASM OF UNCERTAIN BEHAVIOR SITE UNSPECIFIED
239.0	NEOPLASM OF UNSPECIFIED NATURE OF DIGESTIVE SYSTEM
239.1	NEOPLASM OF UNSPECIFIED NATURE OF RESPIRATORY SYSTEM
239.2	NEOPLASM OF UNSPECIFIED NATURE OF BONE SOFT TISSUE AND SKIN
239.3	NEOPLASM OF UNSPECIFIED NATURE OF BREAST
239.4	NEOPLASM OF UNSPECIFIED NATURE OF BLADDER

239.5	NEOPLASM OF UNSPECIFIED NATURE OF OTHER GENITOURINARY ORGANS
239.6	NEOPLASM OF UNSPECIFIED NATURE OF BRAIN
239.7	NEOPLASM OF UNSPECIFIED NATURE OF ENDOCRINE GLANDS AND OTHER PARTS OF NERVOUS SYSTEM
239.89	NEOPLASMS OF UNSPECIFIED NATURE, OTHER SPECIFIED SITES
239.9	NEOPLASM OF UNSPECIFIED NATURE SITE UNSPECIFIED
250.60	DIABETES WITH NEUROLOGICAL MANIFESTATIONS, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED
250.61	DIABETES WITH NEUROLOGICAL MANIFESTATIONS, TYPE I [JUVENILE TYPE], NOT STATED AS UNCONTROLLED
333.71 - 333.79	ATHETOID CEREBRAL PALSY - OTHER ACQUIRED TORSION DYSTONIA
334.1	HEREDITARY SPASTIC PARAPLEGIA
336.9	UNSPECIFIED DISEASE OF SPINAL CORD
337.1	PERIPHERAL AUTONOMIC NEUROPATHY IN DISORDERS CLASSIFIED ELSEWHERE
337.20 - 337.29	REFLEX SYMPATHETIC DYSTROPHY UNSPECIFIED - REFLEX SYMPATHETIC DYSTROPHY OF OTHER SPECIFIED SITE
338.11 - 338.19	ACUTE PAIN DUE TO TRAUMA - OTHER ACUTE PAIN
338.21	CHRONIC PAIN DUE TO TRAUMA
338.22	CHRONIC POST-THORACOTOMY PAIN
338.29	OTHER CHRONIC PAIN
338.3	NEOPLASM RELATED PAIN (ACUTE) (CHRONIC)
338.4	CHRONIC PAIN SYNDROME
340	MULTIPLE SCLEROSIS
342.10 - 342.12	SPASTIC HEMIPLEGIA AND HEMIPARESIS AFFECTING UNSPECIFIED SIDE - SPASTIC HEMIPLEGIA AND HEMIPARESIS AFFECTING NONDOMINANT SIDE
343.0 - 343.9	CONGENITAL DIPLEGIA - INFANTILE CEREBRAL PALSY UNSPECIFIED
344.5	UNSPECIFIED MONOPLEGIA
344.81	LOCKED-IN STATE
344.89	OTHER SPECIFIED PARALYTIC SYNDROME
344.9	PARALYSIS UNSPECIFIED
353.0	BRACHIAL PLEXUS LESIONS
353.1	LUMBOSACRAL PLEXUS LESIONS
353.2	CERVICAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.3	THORACIC ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.4	LUMBOSACRAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.5	NEURALGIC AMYOTROPHY
353.6	PHANTOM LIMB (SYNDROME)

354.0 - 354.9	CARPAL TUNNEL SYNDROME - MONONEURITIS OF UPPER LIMB UNSPECIFIED
355.4	LESION OF MEDIAL POPLITEAL NERVE
355.71 - 355.79	CAUSALGIA OF LOWER LIMB - OTHER MONONEURITIS OF LOWER LIMB
356.9	UNSPECIFIED IDIOPATHIC PERIPHERAL NEUROPATHY
357.1 - 357.4	POLYNEUROPATHY IN COLLAGEN VASCULAR DISEASE - POLYNEUROPATHY IN OTHER DISEASES CLASSIFIED ELSEWHERE
357.5	ALCOHOLIC POLYNEUROPATHY
357.6	POLYNEUROPATHY DUE TO DRUGS
357.7	POLYNEUROPATHY DUE TO OTHER TOXIC AGENTS
357.81 - 357.89	CHRONIC INFLAMMATORY DEMYELINATING POLYNEURITIS - OTHER INFLAMMATORY AND TOXIC NEUROPATHY
722.0	DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.11	DISPLACEMENT OF THORACIC INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.4	DEGENERATION OF CERVICAL INTERVERTEBRAL DISC
722.51	DEGENERATION OF THORACIC OR THORACOLUMBAR INTERVERTEBRAL DISC
722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
722.71	INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY CERVICAL REGION
722.72	INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY THORACIC REGION
722.73	INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY LUMBAR REGION
722.81	POSTLAMINECTOMY SYNDROME OF CERVICAL REGION
722.82	POSTLAMINECTOMY SYNDROME OF THORACIC REGION
722.83	POSTLAMINECTOMY SYNDROME OF LUMBAR REGION
723.0 - 723.9	SPINAL STENOSIS IN CERVICAL REGION - UNSPECIFIED MUSCULOSKELETAL DISORDERS AND SYMPTOMS REFERABLE TO NECK
724.00 - 724.9	SPINAL STENOSIS OF UNSPECIFIED REGION - OTHER UNSPECIFIED BACK DISORDERS
733.13	PATHOLOGICAL FRACTURE OF VERTEBRAE
789.00 - 789.09	ABDOMINAL PAIN UNSPECIFIED SITE - ABDOMINAL PAIN OTHER SPECIFIED SITE
907.2	LATE EFFECT OF SPINAL CORD INJURY

953.0	INJURY TO CERVICAL NERVE ROOT
953.1	INJURY TO DORSAL NERVE ROOT
953.2	INJURY TO LUMBAR NERVE ROOT
953.3	INJURY TO SACRAL NERVE ROOT
953.4	INJURY TO BRACHIAL PLEXUS
953.5	INJURY TO LUMBOSACRAL PLEXUS
953.8	INJURY TO MULTIPLE SITES OF NERVE ROOTS AND SPINAL PLEXUS
V58.61*	LONG-TERM (CURRENT) USE OF ANTICOAGULANTS

* Use only as a supplemented code in addition to the primary diagnosis, when anticoagulant therapy has been temporarily discontinued to facilitate therapeutic injections for pain management.

Diagnoses that Support Medical Necessity
N/A
ICD-9 Codes that DO NOT Support Medical Necessity
N/A

XX000	Not Applicable

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity
N/A
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General Information

Documentations Requirements

Medical necessity for providing the service must be clearly documented in the patient's medical record and submitted upon request for review.

Assessment of the outcome of this procedure depends on the patient's responses, therefore documentation should include:

- Whether the block was a diagnostic or therapeutic injection
- Pre and post procedure evaluation of patient
- Patient education
- Subjective and objective response from the patient regarding pain provocative maneuvers documented by pre and post procedure measurement
- According to the American Society of Interventional Pain Physicians (ASIPP) guidelines, a positive response to a series of three (3) epidural injections, is noted when > 50 % relief is obtained for 6 to 8 weeks.

Appendices

Utilization Guidelines - It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

- It is expected that providing an epidural block in conjunction with multiple facet joint blocks, bilateral sacroiliac joint injections, trigger point injections, and/or lumbar sympathetic blocks in any combination to a patient on the same day is not considered medically necessary, unless the patient has recently discontinued anticoagulant therapy for the purpose of interventional pain management. It is expected that interlaminar, transforaminal or caudal epidural injections are not performed on the same date of service at the same level.

- Procedures performed during the diagnostic phase should be limited to two (2) injections.

- Once a structure is proven to be negative as a pain generator, no repeat interventions should be directed at that structure unless there is a new clinical presentation with symptoms, signs, and diagnostic studies of known reliability and validity that implicate the structure.

- In the treatment or therapeutic phase, a series of three (3) injections may be given at a minimum interval of two (2) weeks to the suspect level. If a positive response (per ASIPP guidelines) is not obtained, then a repeat series of injections at that level is considered not medically necessary.

- It is not expected that a patient would undergo an epidural injection at more than two (2) levels (unilateral or bilateral) on any given date of service. (A level is defined as the articulation between two vertebrae i.e., C4-5; or L2-3).

- A series of three (3) epidural injections may be repeated at six (6) month intervals (assuming there was a positive response as defined by the ASIPP guidelines) to the first series of three (3) injections. Caution should be used to monitor the side effects of frequent steroid use.

- Under unusual circumstances with a recurrent injury, carcinoma, or reflex sympathetic dystrophy, blocks may be repeated more frequently in the treatment phase after stabilization. Documentation must be present in the medical record to support the more frequent use of such therapy in this setting.

Sources of Information and Basis for Decision

Boswell, M.V., Hansen, H.C., Trescot, A.M., Hrish, J.A. (2003). Epidural steroids in the management of chronic spinal pain and radiculopathy. Pain Physician. 6(3) 319-334.

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Manchikanti, L., Singh, V., Kloth, D., Slipman, C.W., Jasper, J., Trescot, A.M., Varley, K.G., Alturi, S.L., Giron, C., Curran, M.J., Rivera, J., Baha, A.G., Bakhit, C.E., and Reuter, M.W. (2001). Interventional techniques in the management of chronic pain. Pain Physician 4(1) 24-98.

Miller, R.D. (2000). Miller: Anesthesia, 5th ed. Philadelphia: Churchill Livingstone.

National Guideline Clearinghouse. (2002). Complex regional pain syndrome (CRPS). Retrieved from the internet September 14, 2004.

Olorunto, W.A., Galandiak, S. (2006). Managing the spectrum of surgical pain: acute management of the chronic pain patient. Journal of the Americal College of Surgeons.

Advisory Committee Meeting Notes

This Local Coverage Determination (LCD) does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this LCD was developed in cooperation with advisory groups, which includes representatives from numerous societies.

Start Date of Comment Period

End Date of Comment Period

Start Date of Notice Period 01/01/2011

Revision History Number 3

Revision History Explanation Revision Number:3
Start Date of Comment Period:N/A
Start Date of Notice Period:01/01/2012
Revised Effective Date: 01/01/2012

LCR B2012-007
December 2011 Connection

Explanation of Revision: Annual 2012 HCPCS Update. Descriptors revised for CPT codes 62310 and 62311. The effective date of this revision is based on date of service.

Revision Number:2
Start Date of Comment Period:N/A
Start Date of Notice Period:01/01/2011
Revised Effective Date: 01/01/2011

LCR B2011-007
December 2010 Update

Explanation of Revision: Annual 2011 HCPCS Update. Revised descriptors for CPT codes 64479, 64480, 64483 and 64484 in LCD. The effective date of this revision is based on date of service.

Revision Number:1
Start Date of Comment Period:N/A
Start Date of Notice Period:10/01/2009
Revised Effective Date: 10/01/2009

LCR B2009-098
September 2009 Update

Explanation of Revision: Annual 2010 ICD-9-CM Update. Added diagnosis codes 209.70-209.79 and 239.89. The effective date of this revision is based on date of service.

Revision Number:Original
Start Date of Comment Period:N/A
Start Date of Notice Period:12/04/2008
Revised Effective Date:02/02/2009

LCR B2009-
December 2008 Bulletin

This LCD consolidates and replaces all previous policies and publications on this subject by the carrier predecessors of First Coast Service Options, Inc. (Triple S and FCSO).

For Florida (00590) this LCD (L29165) replaces LCD L6443 as the policy in notice. This document (L29165) is effective on 02/02/2009.

08/08/2009 - This policy was updated by the ICD-9 2009-2010 Annual Update.

09/06/2010 - This policy was updated by the ICD-9 2010-2011 Annual Update.

11/21/2010 - For the following CPT/HCPCS codes either the short description and/or the long description was changed. Depending on which description is used in this LCD, there may not be any change in how the code displays in the document:
64479 descriptor was changed in Group 2
64480 descriptor was changed in Group 2
64483 descriptor was changed in Group 2
64484 descriptor was changed in Group 2

08/27/2011 - This policy was updated by the ICD-9 2011-2012 Annual Update.

11/21/2011 - For the following CPT/HCPCS codes either the short description and/or the long description was changed. Depending on which description is used in this LCD, there may not be any change in how the code displays in the document:
62310 descriptor was changed in Group 1
62311 descriptor was changed in Group 1
64479 descriptor was changed in Group 2
64480 descriptor was changed in Group 2
64483 descriptor was changed in Group 2
64484 descriptor was changed in Group 2

Reason for Change

Related Documents
This LCD has no Related Documents.

LCD Attachments
Coding Guidelines effective 01/01/2011

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All Versions

Updated on 12/05/2011 with effective dates 01/01/2012 - N/A
Updated on 12/15/2010 with effective dates 01/01/2011 - 12/31/2011
Updated on 09/25/2009 with effective dates 10/01/2009 - 12/31/2010
Updated on 11/30/2008 with effective dates 02/02/2009 - N/A
Read the **LCD Disclaimer**
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