



Spinal and Trigger Point Injections

I. Policy

University Health Alliance (UHA) will reimburse for nonsurgical interventional treatment for subacute and chronic spinal pain when determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Background

Multiple treatment options for subacute and chronic low back pain are available. Broadly, these are divided into pharmacologic and non-interventional treatments, nonsurgical interventional treatments, and surgical treatments. **This policy will address the following nonsurgical interventional procedures for patients with subacute and chronic neck and low back pain who have failed conservative management:**

- Epidural injections;
- Facet joint injections;
- Facet neurolysis;
- Sacroiliac joint injections; and
- Trigger point injections.

III. Criteria/Guidelines

UHA considers the following nonsurgical interventional treatments for spinal pain management, subject to administrative limitations and criteria as noted below, to be medically necessary for the treatment of subacute or chronic neck or back pain.

A. All procedures require documentation that the treating provider has a clear understanding of the patient's medical history and pain management plan. The following criteria apply to all procedures:

1. **Clinical notes must be current, legible, and include *all* of the following:**

- a. A history and physical examination (including an appropriately focused musculoskeletal and neurological physical examination);
 - i. UHA understands that many patients with chronic pain are well known to their pain management providers, and a comprehensive evaluation may not be indicated on each visit. However, in all instances where a new or repeat interventional pain management procedure is part of the plan of care, a current evaluation including a focused history and exam in addition to all the criteria below are mandatory for coverage of services.
 - ii. Extensive cloning of prior notes does not qualify as an adequate current evaluation.
- b. The nature of the suspected organic problem;
- c. Conditions which may be contraindications to procedure;
- d. A summary of pertinent diagnostic tests or procedures;
- e. Clear documentation of all prior nonsurgical interventions (injections) relevant to patient's current pain symptoms, to include date(s) of service and patient's response;
- f. Intraspinal tumor or other space-occupying lesion, or non-spinal origin for pain, has been ruled out as the cause of pain;

- g. In the instances of repeat procedures or neurolysis, clear and complete details of patient response to prior interventions is required. Such details are not a substitute for a suitable evaluation of the patient;
 - h. Documentation of current and average pain level and functional disability.
 - i. Documentation that member has failed to achieve adequate improvement after conservative treatments in the absence of a contraindication and when utilized appropriately in the timing of treatment;
 - i. Conservative treatment may include a multimodality approach consisting of a combination of active and inactive components. Inactive components may include rest, ice, heat, modified activities, medical devices, acupuncture and/or stimulators, medications, and diathermy. Active modalities may consist of physical therapy, a physician supervised home exercise program, and/or chiropractic care.
 - ii. If there is a medical reason this conservative treatment cannot be done, the reason(s) must be clearly documented.
 - iii. When Physical Therapy is indicated for a member's diagnosis, therapy must meet accepted standard of care guidelines and must be active/exercise based. Documentation of type and duration of physical therapy must be made available on request.
 - j. Documentation that procedure(s) are being considered as part of a comprehensive pain management program, which includes physical therapy, patient education, psychosocial support, and oral medications, where appropriate; and
 - i. Procedures planned as an isolated intervention for diagnosing or treating a patient's neck or back pain without clear documentation of how the patient's response may impact a comprehensive pain management program may not meet medical necessity criteria and may be denied.
 - k. Clear documentation of type of planned procedure (e.g., ESI, MBB, RFA), spinal level(s) to be injected (to include left, right, or bilateral), and approach (e.g., interlaminar, transforaminal). Abbreviated plan of care such as "Repeat ESI" will not qualify as adequate documentation.
2. Prior to performing any procedure, shared decision-making between patient and physician must occur, and the patient must understand the procedure and its potential risks and results, such as moderate short-term benefits and lack of long-term benefits.
 3. Only one invasive modality or procedure will be considered medically necessary per date of service, per region (cervical, lumbar, SIJ).
 4. UHA considers ultrasound guidance of any injections for pain treatment experimental and investigational because of insufficient evidence of its effectiveness.
- B. General anesthesia or monitored anesthesia care (MAC) is not a covered service when provided in conjunction with the procedures referenced in this policy. Standard medical practice utilizes local anesthesia or conscious sedation.
- C. Epidural injections of corticosteroid preparations, with or without added anesthetic agents, may be considered medically necessary in the outpatient setting for management of persons with neck or back pain when *all* of the following are met:
1. Pain is radicular in nature (radicular signs may include, but are not limited to, a positive straight leg raise or a dermatomal pattern of pain and/or sensory loss).
 2. Patient is experiencing subacute pain or exacerbation of chronic radicular pain within the following clinical criteria:

- a. Average pain levels of ≥ 6 on a scale of 0-10 or intermittent or continuous pain causing functional disability;
 - b. **Two weeks or more** of neck or back pain with acute radicular pain that has failed to respond or has poorly responded to appropriate conservative management unless the medical reason this conservative treatment cannot be done is clearly documented; or
 - c. Failed back surgery syndrome or epidural fibrosis causing radicular pain:
 - i. Typically not done immediately post-surgery. Documentation requires a medical reason that clearly indicates why an injection is needed.
 - ii. Patient must engage in some form of other appropriate conservative treatment **for a minimum of 6 weeks** prior to epidural injections unless the medical reason this conservative treatment cannot be done is clearly documented; or
 - d. Spinal stenosis (foraminal, central, or disc disease) causing radicular pain.
 - i. Patient must engage in some form of other appropriate conservative treatment **for a minimum of 6 weeks** prior to epidural injections unless the medical reason this conservative treatment cannot be done is clearly documented.
- D. Repeat epidural injections may be considered medically necessary if *all* of the following criteria are met. Note: Each repeat epidural injection requires prior authorization. There is no role for a “series of three” epidurals. Response to each epidural should be determined prior to consideration of a repeat epidural and the method used.
- 1. The patient continues to have ongoing pain or documented functional disability (≥ 6 on a scale of 0-10);
 - 2. There is documentation that the prior epidural injection(s), regardless of approach, resulted in substantial relief such that placebo or initial local anesthetic effects cannot reasonably be responsible, in no instance less than a 50% relief in pain or significant functional improvement.
 - a. After three epidural injections within any 12 month period, regardless of approach, patient must experience at least 50% or more cumulative pain relief **for a minimum of 6 weeks** to be considered a positive and effective response and for additional injections to be considered medically necessary; and
 - 3. Injections must meet the following criteria:
 - a. No more than 3 levels of ESI should be done in one day;
 - b. There must be at least 14 days between injections;
 - c. No more than 3 procedures in a 12-week period of time per region;
 - d. Limited to a maximum total of 6 procedures per region per 12 months; and
 - e. After 6 procedures, additional therapeutic steroid injections are covered only after spinal surgical evaluation is obtained, and the consultant concurs with the treatment plan.
- E. Facet joint injections may be considered medically necessary to diagnose or treat disabling non-radicular low back (lumbosacral) or neck (cervical) pain suggestive of facet joint origin when *all* the following criteria are documented in the medical record:
- 1. History consists of mainly axial or non-radicular pain;
 - 2. Lack of evidence for discogenic (radicular) or sacroiliac joint pain, or if such symptoms exist, there is documented evidence to suspect facet as an additional pain generator;

3. Facet blocks are not performed at same levels as previous surgical fusion;
 4. Patient has documented intermittent or continuous pain with average pain levels of ≥ 6 on a scale of 0 to 10 or functional disability; and
 5. Failure to respond to appropriate conservative non-operative therapy management for a minimum of **6 weeks in the last 6 months prior to facet injections** unless the medical reason this treatment cannot be done is clearly documented.
- F. Repeat facet joint injections may be considered medically necessary when *all* of the following criteria are met:
1. There must be a **minimum of 14 days** between injections;
 2. There must be a positive response of $\geq 50\%$ pain relief or improved ability to function from the prior facet block procedure;
 3. The patient is actively engaged in other forms of conservative non-operative treatment if the patient is receiving therapeutic facet joint injections unless pain prevents the patient from participating in conservative therapy;
 4. Maximum of 3 procedures per region (cervical or lumbar) every 6 months; and
 5. Maximum of 3 levels injected on the same date of service.
- G. Paravertebral Facet Joint Denervation (radiofrequency neurolysis) may be considered medically necessary when *all* of the following criteria are met:
1. The presence of *all* of the following:
 - a. Lack of evidence that the primary source of pain being treated is from discogenic pain, disc herniation, or radiculitis;
 - b. Intermittent or continuous facet-mediated pain (average pain levels of ≥ 6 on a scale of 0 to 10) causing functional disability prior to each radiofrequency procedure including radiofrequency procedures done unilaterally on different days; and
 - c. Duration of pain of at least 3 months.
 2. Initial RFA requires positive response to 1 or 2 controlled (diagnostic) local anesthetic blocks of the facet joint/MB nerve, with at least 50% pain relief and/or improved ability to function, but with insufficient sustained relief (less than 2-3 months relief), and a failure to respond to more appropriate conservative non-operative management for a minimum of 6 weeks unless the medical reason this treatment cannot be done is clearly documented.
 3. **Repeat RFA** requires positive response to prior radiofrequency neurolysis procedures with at least 50% pain relief and/or improved ability to function for **at least 6 months**, and the patient is actively engaged in other forms of appropriate conservative non-operative treatment (unless pain prevents the patient from participating in conservative therapy).
 4. Medical necessity is limited to 2 facet neurolysis procedures every 12 months, per region (cervical or lumbar).
- H. Sacroiliac joint (SIJ) injections may be considered medically necessary when provided as part of a comprehensive pain management program and when they meet the following criteria:
1. Controlled SIJ injections are indicated for **diagnosis** of SIJ pain when a diagnosis cannot be made using less invasive options, including physical examination and imaging studies, and when the controlled SIJ injection will support a chosen treatment strategy. *All* of the following are required:
 - a. Low back pain maximal below level of L5 persisting at least 3 months; and

- b. Diagnosis remains uncertain following physical examination and (if indicated) imaging studies;
 2. A positive response to a diagnostic SIJ injection requires documented evidence of 75-100% pain relief.
 3. Sacroiliac joint (SIJ) injections (intraarticular or periarticular) are considered medically necessary for **treatment** of SIJ pain in members who have back pain below level of L5 persisting for more than 3 months with history and physical exam findings consistent with SIJ as pain generator.
 4. Sacroiliac joint (SIJ) injections are considered medically necessary for **treatment** of sacroiliac pain with diagnosis of **spondyloarthropathy**.
- I. Repeat SIJ injections may be considered medically necessary if all the following criteria are met:
 1. Symptoms recur and the patient experienced at least a 50% improvement after prior SIJ injection; and
 2. Repeat injections are not performed more frequently than every six weeks for a maximum of 4 injections in a 12 month period.
- J. Note: Radiofrequency ablation of the sacroiliac joint is not a covered service as there is insufficient evidence to determine the effects of radiofrequency ablation of the sacroiliac joint on health outcomes.
- K. Trigger point injections of corticosteroids and/or local anesthetics, are considered medically necessary for treating members with chronic neck or back pain or, when *all* of the following selection criteria are met:
 1. Symptoms have persisted for more than 3 months;
 2. Trigger points have been identified by palpation;
 3. Trigger point injections are not administered in isolation but are provided as part of a comprehensive pain management program, including physical therapy, patient education, psychosocial support, and oral medication where appropriate; and
 4. A trigger point is defined as a specific point or area where, if stimulated by touch or pressure, a painful response will be induced. A set of trigger point injections means injections in several trigger points in one sitting. Billing requires providers to specify the number of injections and muscle groups being treated.
 - a. UHA defines "muscle group" as several muscles in a region attached to a point (e.g., shoulder or knee). In accordance with this definition, the following examples may help the practitioner to determine how many muscle groups have been injected:
 - i. If the right trapezius, supraspinatus, and infraspinatus muscles are injected, one muscle group has been injected.
 - ii. If both the left and right trapezius muscles have been injected, two muscle groups have been injected.
 - iii. If the left trapezius, left gluteus, and plantar fascial fibromatosis are injected, three muscle groups have been injected.
 5. Frequency of trigger point injections:
 - a. It is not considered medically necessary to repeat injections more frequently than every 7 days.
 - b. Up to 4 sets of injections are considered medically necessary to diagnose the origin of a patient's pain and achieve a therapeutic effect; additional sets of trigger point injections are not considered medically necessary if no clinical response is achieved.

- c. Once a diagnosis is established and a therapeutic effect is achieved, it is rarely considered medically necessary to repeat trigger point injections more frequently than once every 2 months.
- d. Repeated injections extending beyond 12 months may be reviewed for continued medical necessity.

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members' individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

IV. Administrative Guidelines

- A. Prior Authorization is not required.
- B. At the discretion of the Medical Director, UHA may request notes to review for compliance with this policy. Compliance will rest upon current standards of care and documented evidence that all criteria above have been met.
- C. UHA follows the CPT guidelines of CMS/Noridian for Spinal injections. Providers should ensure that their Prior Authorization/billing staff remain cognizant of the following:
 - 1. Spinal injections (e.g., ESI and facet injections; 64479-64484 and 64490-64495, et al) are inherently UNILATERAL procedures and are to be billed once per spinal level, per side (LT or RT) regardless of the number of needle placements that are required.
 - 2. When spinal injection CPT codes INCLUDE fluoroscopic guidance the addition of CPT code 77003 (fluoroscopic guidance) is INCORRECT and double bills for the fluoroscopy portion of the procedure.
 - 3. For injections performed on both sides of one vertebral level (bilateral), the correct coding is to report the base injection code with modifier -50 (Bilateral procedure).
 - 4. Clinic notes should clearly document the type of planned procedure (e.g., ESI, MBB), planned approach (e.g., interlaminar, transforaminal) and specific spinal levels (to include LT, RT or Bilateral)..
- D. A hard (plain radiograph with conventional film or specialized paper) or digital copy image or images which adequately document the needle position and (when applicable) contrast medium must be retained and submitted if requested.
- E. This policy may apply to the following codes. Inclusion of a code in the table below does not guarantee that it will be reimbursed.

CPT	Description
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed

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)
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)
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)
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)
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)
0228T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level
0229T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (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)
G0260	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography

V. Policy History

Policy Number: MPP-0124-170401

Current Effective Date: 10/18/19

Original Document Effective Date: 04/01/2017

Previous Revision Dates: 04/01/2017, 11/01/2017, 01/01/2018, 03/19/2018

PAP Approved Date: 03/21/2017

Previous Policy Title: Nonsurgical Interventional Treatments for Spinal Pain Management