

# Clinical Policy: Pain Management Procedures

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[Revision Log](#)

## **IMPORTANT REMINDER**

This Clinical Policy has been developed by appropriately experienced and licensed health care professionals based on a thorough review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by the policy; and other indicia of medical necessity. Centene Corporation makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this policy.

The purpose of this Clinical Policy is to provide a guide to medical necessity. Benefit determinations should be based on the applicable contract provisions governing plan benefits (“Benefit Plan Contract”) and applicable state and federal requirements, as well as applicable plan-level administrative policies and procedures. To the extent there are any conflicts between this Clinical Policy and the Benefit Plan Contract provisions, the Benefit Plan Contract provisions will control.

Clinical policies are intended to be reflective of current scientific research and clinical thinking. This policy is current at the time of approval, may be updated and therefore is subject to change. This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members.

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**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this Policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

## **Description**

Invasive pain management procedures considered in this policy include facet joint diagnostic and therapeutic blocks and radiofrequency ablation, sacroiliac joint injections, epidural steroid injections/selective nerve root blocks, percutaneous adhesiolysis, trigger point injections, trochanteric bursa injections, sympathetic blocks, lumbar discography and spinal cord stimulation.

## **Policy/Criteria**

It is the policy of health plans affiliated with Centene Corporation® that invasive pain management procedures performed by a physician are medically necessary when *the relevant criteria are met and the patient receives only one procedure per visit, with or without radiographic guidance.*

**CLINICAL POLICY**  
**Pain Management Procedures**

I.	Epidural steroid injections (ESI)/selective nerve root blocks (SNRB) .....	2
II.	Facet Joint Interventions .....	3
III.	Sacroiliac Joint (SIJ) Interventions .....	4
IV.	Epidural Adhesiolysis .....	4
V.	Intradiscal Steroid Injection .....	4
VI.	Mechanical Disc Decompression .....	4
VII.	Discography .....	4
VIII.	Spinal Cord Stimulation .....	5
IX.	Trigger Point Injections .....	6
X.	Local Injections for Cervicogenic and Occipital Neuralgia .....	7
XI.	Peripheral/Ganglion Nerve Blocks for the Treatment of Chronic Nonmalignant Pain .....	7
XII.	Sympathetic Nerve Blocks .....	7

**I. Epidural steroid injections (ESI)/selective nerve root blocks (SNRB)**

- A. Up to two *diagnostic ESI/SNRBs* given at least 2 weeks apart for **chronic** pain are considered **medically necessary** to establish a diagnosis and confirm beneficial response when all of the following are met:
  - 1. Persistent radicular pain caused by spinal stenosis, disc herniation or degenerative changes in the vertebrae, that interferes with ADLs that has lasted for at least 3 months, *and*
  - 2. Patient has failed to respond to conservative therapy including all of the following:
    - a.  $\geq 6$  weeks chiropractic, physical therapy or prescribed home exercise program, *and*
    - b. NSAID  $\geq 3$  weeks or NSAID contraindicated or not tolerated, *and*
    - c.  $\geq 6$  weeks activity modification.
  
- B. If no improvement is seen after the first two injections, subsequent *ESI/SNRBs* are considered **experimental/investigational** because effectiveness has not been established.
  
- C. If recurrence of symptoms occurs after a favorable response to diagnostic injections, *therapeutic ESI/SNRBs* are considered **medically necessary** when all of the following are met:
  - 1. There is  $\geq 50\%$  relief for at least 2 months associated with functional improvement from the initial injection(s); *and*
  - 2. ESI/SNRB is given at intervals of no more frequently than every 3 months.
  - 3. A maximum of 4 therapeutic injections may be given at the same site within 12 months.
  
- D. *Continuation of injections* beyond 12 months or more than 4 therapeutic injections is considered **experimental/ investigational** because effectiveness and safety has not been established. When more definitive therapies cannot be tolerated or provided, consideration will be made on a case by case basis.
  
- E. *ESI/SNRB for acute pain management* (pain lasting  $< 3$  months) is considered **medically necessary** when all of the following are met:

1. There is severe radicular pain that interferes substantially with ADLs; and
2. Severe pain persists after treatment with NSAID and/or opiate (both  $\geq 3$  days or contraindicated/not tolerated), and
3. The member cannot tolerate chiropractic or physical therapy and the injection is intended as a bridge to therapy.

F. Requests for ESI/SNRB *for any other indication or location* are considered **experimental/investigational** because effectiveness has not been established.

## **II. Facet Joint Interventions**

- A. Up to two *diagnostic facet joint injections* given at least 2 weeks apart are considered **medically necessary** when all the following criteria are met:
1. Intermittent or continuous back pain that interferes with ADLs has lasted for  $\geq 3$  months, *and*
  2. Patient has failed to respond to conservative therapy including all of the following:
    - a.  $\geq 6$  weeks chiropractic, physical therapy or prescribed home exercise program, *and*
    - b. NSAID  $\geq 3$  weeks or NSAID contraindicated or not tolerated, *and*
    - c.  $\geq 6$  weeks activity modification, *and*
  3. Clinical findings suggest facet joint syndrome and imaging studies suggest no other obvious cause of the pain (eg, disc herniation, radiculitis, discogenic or sacroiliac pain). Physical findings of spinal facet joint syndrome can include low back pain exacerbated on extension and rotation; positive response to facet loading maneuvers or pain worse at night
- B. *Therapeutic facet joint injections* are considered **experimental/investigational** because effectiveness has not been established.
- C. *Facet joint medial branch conventional radiofrequency neurotomy in the lumbar and cervical regions* is considered **medically necessary** in the treatment of chronic back or neck pain when the following criteria are met:
1. Positive response to controlled diagnostic blocks (at each region to be treated) as indicated by  $\geq 80\%$  pain relief with the ability to perform prior painful movements without significant pain, and
  2. Treatment occurs no sooner than one week after a successful diagnostic injection at that spinal region; and
  3. Treatment is repeated no more frequently than every 6 months, and
  4. All regions being treated will be treated at the same time provided all can be performed safely.
- D. *Repeat facet joint medial branch conventional radiofrequency neurotomy of the lumbar and cervical regions* is considered **medically necessary** in the management of chronic back or neck pain when the following criteria are met:
1. At least 6 months have elapsed since the previous treatment; and
  2.  $\geq 50\%$  relief is obtained for at least 4 months with associated functional improvement following the previous treatment; and

3. No more than three spinal levels are to be treated at the same time.

E. *Conventional radiofrequency neurotomy of the facet joints* of the thoracic region is considered **experimental/investigational** because effectiveness has not been established.

### **III. Sacroiliac Joint (SIJ) Interventions**

A. Up to two *diagnostic SIJ injections for the diagnosis of SIJ pain* separated by at least 2 weeks are considered **medically necessary** when the following criteria are met:

1. Somatic or nonradicular low back and lower extremity pain below the level of L5 vertebra that interferes with ADLs for at least 3 months, and
2. Tenderness by palpation present over SIJ, and
3. Patient has failed to respond to conservative therapy including all of the following:
  - a.  $\geq 6$  weeks chiropractic, physical therapy or prescribed home exercise program, and
  - b. NSAID  $\geq 3$  weeks or NSAID contraindicated or not tolerated, and
  - c.  $\geq 6$  weeks activity modification, *and*
4. Clinical findings and imaging studies, when available, lack obvious evidence for disc-related or facet joint pain, and
5. No other possible diagnosis is more likely.

B. If recurrence of symptoms occurs after a favorable response to diagnostic injections, *therapeutic SIJ injections* are considered **medically necessary** when all of the following are met:

1. There is  $\geq 50\%$  relief for at least 2 months associated with functional improvement from the initial injection(s); *and*
2. SIJ injection is given at intervals of no more frequently than every 2 months.
3. A maximum of 4 therapeutic injections may be given at the same site within 12 months

C. *Continuation of injections* beyond 12 months is considered **experimental/investigational** because effectiveness and safety has not been established. When more definitive therapies cannot be tolerated or provided, consideration will be made on a case by case basis.

D. *Radiofrequency neurotomy* of the SIJ is considered **experimental/investigational** because effectiveness has not been established.

### **IV. Epidural Adhesiolysis**

*Epidural adhesiolysis* is considered **experimental/investigational** because effectiveness has not been established.

### **V. Intradiscal Steroid Injection**

*Intradiscal steroid injections* are considered **experimental/investigational** because effectiveness has not been established.

**VI. Mechanical Disc Decompression**

*Mechanical disc decompression* for any indications is considered **experimental/investigational** because effectiveness has not been established.

**VII. Discography**

- A. *Lumbar discography* is considered **medically necessary** for the evaluation of degenerative disc disease when the following criteria are met:
1. The injection is for diagnostic purposes; *and*
  2. The injection is performed at  $\geq 2$  levels; *and*
  3. Chronic discogenic back pain (may extend to buttocks) that interferes with ADLs for at least 6 months, *and*
  4. Patient has failed to respond to conservative therapy including all of the following:
    - d.  $\geq 6$  weeks physical therapy or prescribed home exercise program, *and*
    - e. NSAID  $\geq 3$  weeks or NSAID contraindicated or not tolerated, *and*
    - f.  $\geq 6$  weeks activity modification, *and*
  5. A surgical procedure that is not experimental/investigational is being considered; *and*
  6. MRI has confirmed levels of degenerative disc disease and normal discs to use as potential controls.
- B. *Cervical and thoracic discography* is considered **experimental/investigational** because effectiveness has not been established.

**VIII. Spinal Cord Stimulation**

- A. A *trial of spinal cord stimulation* is considered **medical necessary** for failed back surgery syndrome (FBSS) when all the following criteria are met:
1. Prior lumbar surgery (one of the following):
    - a.  $\geq 2$  prior surgeries at the same level, *or*
    - b.  $\geq 1$  prior surgery at  $> 1$  level, *or*
    - c. Prior spinal fusion surgery. *AND*
  2. Pain lasting  $\geq 6$  months, is refractory and interferes with ADLs; *and*
  3. Patient is not a candidate for additional surgery, *and*
  4. Patient has failed  $\geq 6$  months of conventional multidisciplinary medical therapy including:
    - a. Chiropractic, physical therapy or prescribed home exercise program, *and*
    - b. NSAIDs or NSAIDs contraindicated or not tolerated, *and*
    - c. Activity modification. *And*
  5. Patient has demonstrated cognitive ability to manage stimulator, *and*
  6. Patient has no uncontrolled major psychiatric disorders, *and*
  7. Patient willing to cease any inappropriate drug use prior to implantation.
- B. A *trial of spinal cord stimulation* in the management of *chronic regional pain syndrome* (CRPS) is considered **medically necessary** when the following criteria are met:

1. Pain is being managed by a pain management specialist with experience treating CRPS and pain/burning has persisted for > 6 months, *and*
  2. The patient has  $\geq 2$  of the following symptoms limited to one extremity only:
    - a. Allodynia (pain sensation in response to a typically non-painful stimulus)
    - b. Swelling/tenderness
    - c. Cyanotic/red/pale digit/extremity
    - d. Increased sweating
    - e. Alteration of temperature
    - f. Persistent loss of motion
    - g. Trophic skin changes
    - h. Flexion contractures; *and*
  3. Pain is chronic, refractory, and interferes with ADLs; *and*
  4. Patient has had  $\geq 6$  months of failed conventional multidisciplinary therapy including all of the following:
    - a. Physical therapy or occupational therapy, *and*
    - b. Anticonvulsant or antidepressant medication; *and*
    - c. Sympathetic block; *and*
  5. Patient has demonstrated cognitive ability to manage stimulator, *and*
  6. Patient has no major uncontrolled psychiatric disorders, *and*
  7. Patient willing to cease any inappropriate drug use prior to implantation.
- C. *Spinal cord stimulation* in the management of *refractory chronic stable angina pectoris* has **limited evidence** to prove effectiveness of treatment and consideration will be made on a case by case basis. It should be reserved only for carefully selected patients, if any. Medical necessity will be considered in patients based on the following information:
1. Patient has continued angina after PCI or CABG,
  2. Patient is not a candidate for further revascularization,
  3. Patient's angina is NYHA III (less than ordinary physical activity causes symptoms) or IV (symptoms present at rest),
  4. Patient has had optimal pharmacotherapy for at least one month that includes the maximal tolerated dose of at least 2 of the following:
    - a. Long-acting nitrates
    - b. Beta-adrenergic blockers
    - c. Calcium channel antagonists
  5. Pain is chronic, refractory, and interferes with ADLs,
  6. Patient has demonstrated cognitive ability to manage stimulator,
  7. Patient has no major psychiatric disorders,
  8. Patient willing to cease any inappropriate drug use prior to implantation.
- D. *Permanent placement of a spinal cord stimulator* is **medically necessary** following a trial of spinal cord stimulation for an indication listed above when the following criteria are met:
1. Disease specific criteria for spinal cord stimulation are met; *and*
  2. Documented trial of  $\geq 3$  days; *and*

3. Documented pain reduction of > 50% from the trial associated with functional improvement; *and*
4. The same device used for the trial is used for permanent placement

**IX. Trigger Point Injections**

- A. Trigger point injections of corticosteroids and/or local anesthetics, are considered **medically necessary** for *diagnosis/stabilization* when all of the following are met:
1. Patient has failed  $\geq 3$  weeks of the following conventional multidisciplinary medical therapy:
    - a. Chiropractic, physical therapy, or prescribed home exercise program or the member is unable to tolerate such therapy and the injection is intended as a bridge to therapy, *and*
    - b. NSAID or NSAID contraindicated or not tolerated, *and*
    - c. Activity modification; *and*
  2. Trigger points have been identified by palpation; *and*
  3. Trigger points are located in a *few* discreet areas, and are not associated with widespread areas of muscle tenderness (as with fibromyalgia).

*Up to 4 sets of injections* may be given for diagnosis and stabilization at intervals no more frequently than every 7 days for the same trigger point. A set of trigger point injections means injections in several trigger points in one sitting.

- B. *Therapeutic trigger point injections* are considered **medically necessary** when all of the following are met:
1. Prior injections (diagnostic or therapeutic) resulted in  $\geq 50\%$  improvement for  $\geq 6$  weeks, *and*
  2. There was a return of pain and/or deterioration following 6 weeks of improvement, *and*
  3. Injections are given no more frequently than every 2 months for up to 12 months (maximum of 6 sessions).

**X. Local Injections for Cervicogenic and Occipital Neuralgia**

Local injections of corticosteroids and/or local anesthetics for *cervicogenic and occipital neuralgia* are considered **experimental/investigational** as effectiveness has not been established.

**XI. Peripheral/Ganglion Nerve Blocks for the Treatment of Chronic Nonmalignant Pain**

*Peripheral/ganglion nerve blocks* for any condition not indicated elsewhere in this policy are considered **experimental/investigational** as effectiveness has not been established.

**XII. Sympathetic Nerve Blocks**

- A. *Sympathetic nerve blocks* have **limited evidence** to prove effectiveness of treatment and consideration will be made on a case by case basis. The criteria in 1 through 3 below provide a basis for documenting patient-specific clinical information to help guide clinical decision making.

1. Diagnosis of *complex regional pain syndrome* (CRPS) (also called reflex sympathetic dystrophy)
  - a. Pain is being managed by a pain management specialist with experience treating CRPS, *and*
  - b. Patient is in an active rehabilitation regimen, *and*
  - c. Failed  $\geq 3$  weeks of conservative therapies such as activity modification, exercises, topical capsaicin cream, and oral medical management such as nonsteroidal anti-inflammatories, antidepressants, anticonvulsants and glucocorticoids; *and*
  - d.  $\geq 2$  of the following findings of the involved digit/extremity:
    - i. Allodynia (pain sensation in response to a typically non-painful stimulus)
    - ii. Swelling/tenderness
    - iii. Cyanotic/red/pale digit/extremity
    - iv. Increased sweating
    - v. Alteration of temperature
    - vi. Persistent loss of motion; *and*
2. Diagnosis of *ischemic limb pain*
  - a. Intractable pain at rest or non-healing ulcer; *and*
  - b. Severe peripheral artery disease by angiogram or doppler; *and*
  - c. Patient not a candidate for revascularization (lesion(s) not amenable to reconstruction, lesion(s) not amenable to angioplasty, patient with comorbid condition or previous failed revascularization); *and*
3. Diagnosis of *pancreatic cancer* with severe abdominal/back pain

B. Celiac nerve block for *acute or chronic pancreatitis* is considered **experimental/investigational** as effectiveness has not been established.

### **Background**

Pain adversely affects the function and wellbeing of an individual. Chronic pain can be persistent or episodic in duration or intensity. Invasive pain management procedures considered in this policy include facet joint diagnostic and therapeutic blocks and radiofrequency ablation, sacroiliac joint injections, epidural steroid injections/selective nerve root blocks, percutaneous adhesiolysis, trigger point injections, trochanteric bursa injections, sympathetic blocks, lumbar discography and spinal cord stimulation.

All other procedures not specifically addressed in this policy will be submitted for secondary medical review.

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## CLINICAL POLICY

### Pain Management Procedures

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**CLINICAL POLICY**  
**Pain Management Procedures**

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**Coding Implications**

The following codes are for informational purposes only. They are current at time of review of this policy. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
20553	Injection(s); single or multiple trigger point(s), 3 or more muscle(s)
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed
62263	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days
62264	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day
62280	Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; subarachnoid
62281	Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic
62282	Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal)
62287	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with the use of an endoscope, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar
62290	Injection procedure for discography, each level; lumbar
62291	Injection procedure for discography, each level; cervical or thoracic
62292	Injection procedure for chemonucleolysis, including discography, intervertebral disc, single or multiple levels, lumbar
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)

**CLINICAL POLICY**  
**Pain Management Procedures**

62318	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic
62319	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
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)
64505	Sympathetic nerve block: sphenopalatine ganglion
64508	Sympathetic nerve block, carotid sinus
64510	Sympathetic nerve block, stellate ganglion (cervical sympathetic)
64517	Sympathetic nerve block, superior hypogastric plexus
64520	Sympathetic nerve block, lumbar or thoracic (paravertebral sympathetic)
64530	Sympathetic nerve block, celiac plexus
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, single facet joint
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)

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**ICD-9-CM Diagnosis Codes that Support Coverage Criteria**

ICD-9-CM Code	Description

**CLINICAL POLICY**  
**Pain Management Procedures**

**ICD-10-CM Diagnosis Codes that Support Coverage Criteria**

ICD-10-CM Code	Description

Reviews, Revisions, and Approvals	Date	Approval Date
Physical Med & Rehab specialist review	06/13	08/13
Therapeutic facet joint injections changed to experimental Trochanteric bursa injection criteria removed as it does not require PA Removed one year limit for 2.D Removed pain scale criteria from II.A Physical Med & Rehab and Anesthesiology PM specialist review	08/14	08/14
Clarified language in ESI section, criteria remained the same	09/14	N/A
Added neurostimulator CPT codes	02/15	N/A
Updated formatting and bullets In I.A added “given at least 2 weeks apart” In I.D added “or more than 4 injections” for continuation of injections In I.E removed “sustained” and added “or” for NSAIDs/opiates failure In II.A added max of 2 diagnostic injections and at least 2 weeks apart II.C. Removed no prior spinal fusion surgery IX. A. Removed pain persistent for 3 months and changed failure of therapy to 3 weeks and added unless provided as a bridge to therapy IX.B. Clarified all language and removed bullet point that injections beyond 12 months are experimental X.A. Clarified language Therapeutic SIJ injections added per Specialist recommendation Specialist reviewed	08/15	08/15

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