Epidural Steroid Injections (for Louisiana Only)

Policy Number: CS039LA1.D
Effective Date: September 20, 2023

Instructions for Use

Content mandated by Louisiana Department of Health

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Application

This Medical Policy only applies to the state of Louisiana. The coverage rationale contained in this policy represents Louisiana Medicaid coverage policy and is set forth below in accordance with state requirements.

Coverage Rationale

Pain Management

Medical necessity for epidural steroid injection (ESI) shall be determined by the following:

- History of illness,
- Physical examination, and
- Concordant diagnostic imaging supporting radiculopathy, radicular pain, or neurogenic claudication due to herniation, stenosis, and/or degenerative disease protracted, and severe enough to greatly impact quality of life or function.

If a beneficiary requests treatment for chronic intractable pain, the provider may determine treatment or management to include ESI therapy.

The inclusion of coverage on the *Professional Services Fee Schedule* will define covered treatments.

Certain Medicaid procedures or services may require prior authorization. CPT codes for the treatment of chronic intractable pain requiring PA can be identified on the *Professional Services Fee Schedule*.

Epidurals that are administered for the prevention or control of acute pain, such as that which occurs during delivery or surgery, are covered by the Professional Services Program for this purpose only.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements 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 claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
62320	Injection(s), of diagnostic or therapeutic substance(s) (e.g., 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) (e.g., 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 (i.e., fluoroscopy or CT)
62322	Injection(s), of diagnostic or therapeutic substance(s) (e.g., 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) (e.g., 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 (i.e., 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(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level
*64484	Injection(s), anesthetic agent(s) 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)

Codes labeled with an asterisk (*) are not on the state of Louisiana Medicaid Fee Schedule and therefore may not be covered by the state of Louisiana Medicaid Program.

References

Louisiana Department of Health. Managed Care Organization (MCO) Manual, Professional Services: Pain Management. https://ldh.la.gov/assets/medicaid/Manuals/MCO_Manual.pdf. Accessed August 21, 2023.

Policy History/Revision Information

Date	Summary of Changes

09/20/2023	**Coverage Rationale**
	• Revised language to indicate:
	  ○ Medical necessity for epidural steroid injection (ESI) shall be determined by the following:
	  ▪ History of illness
	  ▪ Physical examination
	  ▪ Concordant diagnostic imaging supporting radiculopathy, radicular pain, or neurogenic claudication due to herniation, stenosis, and/or degenerative disease protracted and severe enough to greatly impact quality of life or function
	  ○ If a beneficiary requests treatment for chronic intractable pain, the provider may determine treatment or management to include ESI therapy
	  ○ The inclusion of coverage on the *Professional Services Fee Schedule* will define covered treatments
	  ○ Certain Medicaid procedures or services may require prior authorization; CPT codes for the treatment of chronic intractable pain requiring PA can be identified on the *Professional Services Fee Schedule*

Date	Summary of Changes
	○ Epidurals that are administered for the prevention or control of acute pain, such as that which occurs during delivery or surgery, are covered by the Professional Services Program for this purpose only **Supporting Information** • Updated *References* section to reflect the most current information • Archived previous policy version CS039LA1.C

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right 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 InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies 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.