MEDICAL POLICY

POLICY TITLE	EPIDURAL STEROID INJECTIONS FOR BACK PAIN
POLICY NUMBER	MP 4.014

CLINICAL BENEFIT	☐ MINIMIZE SAFETY RISK OR CONCERN. ☒ MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. ☐ ASSURE APPROPRIATE LEVEL OF CARE. ☐ ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. ☒ ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. ☐ ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
Effective date:	**5/1/2026**

POLICY

Epidural Steroid Injections

Epidural steroid injections performed with fluoroscopic guidance may be considered **medically necessary** for the treatment of neck or back pain when the following criteria are met:

- Lumbar radiculopathy (sciatica) or cervical radiculopathy that is not responsive to at least 4 weeks of conservative management (see Policy Guidelines section); and
- Persistent pain is present of at least moderate-to-severe intensity; and
- Short-term relief of pain is the anticipated outcome.

Repeat treatment of persistent pain due to radiculopathy or sciatica may be considered **medically necessary** under the following conditions:

- Previous epidural steroid injections were successful at relieving pain; and
- At least 30 days have elapsed since the prior injection (see Policy Guidelines section for maximum number of injections); and
- No more than 6 injections were given over a 12-month period.

Repeat treatment is considered **investigational** in the absence of documentation of benefit from epidural steroid injections. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

Simultaneous treatment of 2 vertebral levels may be considered **investigational** if the criteria above are not met at each level. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

Simultaneous treatment of more than 2 vertebral levels is considered **investigational**. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

Epidural steroid injections are considered **investigational** in all other situations, including but not limited to treatment of spinal stenosis and nonspecific low back pain. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

POLICY TITLE	EPIDURAL STEROID INJECTIONS FOR BACK PAIN
POLICY NUMBER	MP 4.014

The use of fluorography (imaging of the epidural space) as a component of epidural steroid injections is considered **investigational**. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

Policy Guidelines

Epidural Steroid Injections

The diagnosis of lumbar radiculopathy is typically made by a combination of suggestive signs and symptoms in conjunction with imaging that demonstrates compression of a spinal nerve root. Symptoms are due to irritation of the spinal nerve root at L4, L5, or S1, and may include posterior leg pain that extends past the knee, a loss of sensation in a dermatomal pattern, and/or loss of deep tendon reflexes. However, all of these symptoms may not be present. On exam, provocative tests such as the straight leg maneuver are positive. Magnetic resonance imaging is the most useful imaging modality and can confirm or exclude the presence of nerve root compression, most commonly due to herniated disc.

There are several aspects of epidural steroid injection therapy that are not standardized. Expert opinion was sought through clinical vetting on the following issues:

- The optimal time for assessing a response to epidural steroid injections. Expert opinion supports that response can be assessed anytime from immediately to several weeks after the procedure, with the most popular time to assess response being 1 to 2 weeks after injection.
- The definition of a clinically significant response to injections. Expert opinion supports that a reasonable definition of response is at least a 20-point improvement on a 0-to-100 visual analog scale, or an improvement of at least 50% in functional status, when measured using a validated scale.
- The maximum number of injections in 1 year. There is no agreement on the maximum number of injections that should be given in 1 year. Some experts agree that no more than 3 injections should be given in 1 year, but other experts believe that more than 3 per year can be used safely. None of the expert opinions supported more than 6 injections given over a 12-month period.

Conservative nonsurgical therapy for at least 4 weeks should include the following:

- Use of prescription-strength analgesics for several weeks at a dose sufficient to induce a therapeutic response.
  - Analgesics should include anti-inflammatory medications with or without adjunctive medications such as nerve membrane stabilizers or muscle relaxants AND
- Participation in at least 4 weeks of physical therapy (including active exercise) or documentation of why the individual could not tolerate physical therapy, AND
- Evaluation and appropriate management of associated cognitive and behavioral issues

Cross-References:
MP 2.072 Trigger Point and Tender Point Injections

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POLICY NUMBER	MP 4.014

MP 4.050 Facet Joint Injections and Medial Branch Blocks
MP 5.048 Diagnosis and Treatment of Sacroiliac Joint Pain

PRODUCT VARIATIONS

This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations. Please see additional information below.

FEP PPO - Refer to FEP medical policy manual. The FEP medical policy manual can be found at: fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies.

DESCRIPTION/BACKGROUND

Back Pain

Back pain is an extremely common condition. Most episodes are self-limited and will resolve within 1 month, but a small percentage will persist and become chronic. Patients with chronic back pain may suffer from serious disability and may use a high volume of medical services. Despite high utilization, many patients with chronic back pain do not improve with available treatments, including surgical interventions. Therefore, there is a high unmet need to determine the efficacy of different treatments for chronic back pain and to determine which patient populations may benefit from specific interventions. In addition, there has been a proliferation of new technologies, combined with large increases in the number of patients treated and in the intensity of treatment. Therefore, there is a concern for overtreatment of patients who may not benefit from interventions for back pain.

Lumbar or Cervical Radiculopathy

Back pain can result from a variety of underlying causes. Radiculopathy is a subset of back pain that is associated with irritation of 1 or more spinal nerve roots. Symptoms of lumbar radiculopathy, which is sometimes known as sciatica, include pain that radiates down the leg to below the knee, numbness, muscle weakness, and lack of reflexes in a dermatomal distribution. Most patients with radiculopathy respond to conservative care with a resolution of their symptoms within several weeks to several months following onset. In a subset of patients, symptoms and signs of progressive muscle weakness prompt a more aggressive intervention to prevent permanent dysfunction. In other patients, symptoms persist despite conservative management, without progression of neurologic signs, and further treatment options are sought for pain relief.

Spinal Stenosis

Spinal stenosis is another common source of back pain. Spinal stenosis is caused by narrowing of the spinal canal due to degenerative changes, leading to impingement of the spinal cord and the spinal nerve roots. Symptoms of spinal stenosis can include back pain, leg pain with exertion (neurogenic claudication), muscle weakness, and sensory deficits. Definitive treatment for spinal stenosis is surgery, which includes decompression of the spinal canal with or without spinal

fusion. Epidural steroids may reduce inflammation from pressure on the spinal cord and thus reduce symptoms of compression.

Nonspecific Low Back Pain

Nonspecific low back pain, sometimes called mechanical low back pain, is diagnosed when no specific etiology of pain can be identified. Although the etiology of nonspecific low back pain is uncertain, many experts feel that the pain is of discogenic origin or due to painful movement of the vertebrae. In these instances, epidural steroid injections may reduce swelling of the vertebral disc and/or surrounding structures, leading to pain relief.

Treatment

Regardless of specific etiology, conservative management is the first-line treatment for most patients with neck or back pain. Nonsteroidal anti-inflammatory drugs or other analgesics are used for symptom relief. These agents should be used for at least several weeks at a dose sufficient to induce a therapeutic response. Additionally, modification of activity in conjunction with some form of exercise therapy is frequently prescribed early in the course of symptoms and typically involves a physical therapist. For patients with persistent non-radicular back pain, current guidelines recommend interdisciplinary rehabilitation, which is defined as an integrated approach using physical rehabilitation in conjunction with a psychological or psychosocial intervention.

For patients who fail conservative therapy, a number of interventional therapies are available, which range from minimally invasive procedures, such as injections, to major surgeries, such as spinal decompression with fusion. Injections can be given in different locations (e.g., soft tissues, intraspinal, sacroiliac joints) and can use different therapeutic agents (e.g., botulinum toxin, steroids, proteolytic enzymes). Other interventional techniques include radiofrequency ablation, prolotherapy, and chemonucleolysis. Most of these nonsurgical interventions do not have high-quality evidence demonstrating their efficacy. A number of surgical interventions are available, such as discectomy and spinal fusion, each of which can be performed by a variety of techniques. The decision to undertake surgery is best made in the setting of shared decision making between the patient and surgeon, with thorough consideration given to the risks and benefits of surgery.

Epidural Steroid Injections

Epidural injection therapy is one of several therapies available for patients who fail conservative treatment and is one of the most common modalities used in this group of patients. Epidural steroid injections are performed by inserting a needle into the space between the dura and ligamentum flavum and injecting a steroid preparation. There is considerable variability in the technical aspects of epidural injections. Several different approaches may be used for entering the epidural space (translaminar, transforaminal, caudal). In addition, epidural steroid injections may be administered with or without fluoroscopic guidance. Some investigators have estimated that lack of correct needle position in the epidural space may occur in 25% or more of injections administered. Variability of the technique may also involve factors such as the depth of injection into the epidural space, the volume of injectate, and the filling patterns of the injectate.

Treatment is generally given as 1 to 3 injections, each performed at least 1 month apart. Some experts recommend no more than 3 injections in a 12-month period, owing to concerns about the adverse events of chronic steroid administration, both locally and systemically. Others contend that up to 6 injections per year are safe.

Regulatory Status

Steroids are not approved by the U.S. Food and Drug Administration for use as epidural injections; such use represents an off-label administration of a U.S. Food and Drug Administration-approved medication. The specific preparations used for epidural injections are steroids added to a sterile saline solution, which are prepared by a compounding pharmacy.

RATIONALE

Summary of Evidence

For individuals who have lumbar or cervical radiculopathy who receive ESI, the evidence includes RCTs and a number of systematic reviews and meta-analyses of these RCTs. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, medication use, and treatment-related morbidity. The evidence base lacks large-scale, high-quality trials and has a high degree of variability among the available trials in terms of patient populations, epidural injection techniques, and comparison treatments. The results of individual trials are mixed, with some reporting significant benefits for the ESI group and others reporting no benefit. Most systematic reviews did not perform pooled analyses due to the heterogeneity of trials. In the 2 reviews that reported quantitative results, short-term pain relief at up to 6 months follow-up was superior in patients treated with epidural steroids. None of the analyses reported long-term benefits for treatment with ESIs. Adverse events were generally mild but not well reported in these trials. Serious adverse events can occur, but their rate is unknown. However, if short-term relief is the intended outcome and/or patients do not experience relief with conservative therapy, ESI may be a useful option for treatment. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have spinal stenosis who receive ESIs, the evidence includes a moderately large RCT (N=400) and systematic reviews of these RCTs. Relevant outcomes include symptoms, functional outcomes, health status measures, quality of life, medication use, and treatment-related morbidity. The largest RCT and the majority of smaller trials did not report a benefit for ESIs. The evidence is insufficient to determine the effects of technology on health outcomes.

For individuals who have nonspecific low back pain who receive ESIs, the evidence includes systematic reviews of RCTs and nonrandomized studies. Relevant outcomes include symptoms, functional outcomes, health status measures, quality of life, medication use, and treatment-related morbidity. Most trials were of low quality and did not report a benefit for ESIs. The evidence is insufficient to determine the effects of the technology on health outcomes.

POLICY TITLE	EPIDURAL STEROID INJECTIONS FOR BACK PAIN
POLICY NUMBER	MP 4.014

DEFINITIONS

OFF-LABEL USE: The use of a prescription drug or medical device in the treatment of an illness or injury for which it has not been specifically approved by the FDA.

RADICULOPATHY refers to any disease of a nerve root.

DISCLAIMER

Capital Blue Cross' medical policies are used to determine coverage for specific medical technologies, procedures, equipment, and services. These medical policies do not constitute medical advice and are subject to change as permitted by law or applicable clinical evidence from independent treatment guidelines. Treating providers are solely responsible for medical advice and treatment of members. These polices are not a guarantee of coverage or payment. Payment of claims is subject to a determination regarding the member's benefit program and eligibility on the date of service, and a determination that the services are medically necessary and appropriate. Final processing of a claim is based upon the terms of contract that applies to the members' benefit program, including benefit limitations and exclusions. If a provider or a member has a question concerning this medical policy, please contact Capital Blue Cross' Provider Services or Member Services.

CODING INFORMATION

Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Investigational; therefore, not covered, epidural steroid injections without imaging guidance:

Procedure Codes							
62320	62322						

Covered when medically necessary, epidural steroid injections:

Procedure Codes							
62321	62323	64479	64480	64483	64484	77002	

ICD-10-CM Diagnosis Codes	Description
M47.22	Other spondylosis with radiculopathy, cervical region
M47.23	Other spondylosis with radiculopathy, cervicothoracic region

POLICY TITLE	EPIDURAL STEROID INJECTIONS FOR BACK PAIN
POLICY NUMBER	MP 4.014

ICD-10-CM Diagnosis Codes	Description
M47.25	Other spondylosis with radiculopathy, thoracolumbar region
M47.26	Other spondylosis with radiculopathy, lumbar region
M47.27	Other spondylosis with radiculopathy, lumbosacral region
M50.10	Cervical disc disorder with radiculopathy, unspecified cervical region
M50.11	Cervical disc disorder with radiculopathy, high cervical region
M50.121	Cervical disc disorder at C4-C5 level with radiculopathy
M50.122	Cervical disc disorder at C5-C6 level with radiculopathy
M50.123	Cervical disc disorder at C6-C7 level with radiculopathy
M50.13	Cervical disc disorder with radiculopathy, cervicothoracic region
M51.15	Intervertebral disc disorders with radiculopathy, thoracolumbar region
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M54.12	Radiculopathy, cervical region
M54.13	Radiculopathy, cervicothoracic region
M54.15	Radiculopathy, thoracolumbar region
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M54.30	Sciatica, unspecified side
M54.31	Sciatica, right side
M54.32	Sciatica, left side
M54.40	Lumbago with sciatica, unspecified side
M54.41	Lumbago with sciatica, right side
M54.42	Lumbago with sciatica, left side

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POLICY HISTORY

MP 4.014	**02/12/2020 Consensus Review.** Policy statement unchanged. References updated
	11/17/2020 Administrative Update. Codes 0228T, 0229T, 0230T and 0231T deleted. Effective 01/01/2021.
	01/08/2021 Consensus Review. Policy statement unchanged. References updated. Coding reviewed.
	09/07/2021 Administrative Update. Addition of new ICD-10 codes. Effective date 10/01/2021.
	11/22/2022 Consensus Review. For clarity, changed statement section heading from “Facet Joint Nerve Block Injections” to “Facet Joint Injections/Medial Branch Blocks”. No change to intent or coverage. Updated cross-references, FEP, Background, Rationale, and references. Updated coding table.
	12/01/2023 Minor Review. To facet joint/medial branch block, separated out sections with updated criteria for initial diagnostic injection, second diagnostic injection, and therapeutic injections. To epidural section, clarified which approach is eligible for multi-levels and updated time between injections as 14 days instead of 30 days. Updated policy guidelines and references. No changes to coding.
	08/15/2024 Administrative Update. Added/deleted codes as part of New Code Process. Eff date 10/01/2024.
	12/16/2024 Minor Review. Revised criteria for Epidural Steroid Injections. Updated background, rational, dx codes, and references. Procedure codes 62320 and 62322 moved to INV coding table. 77002 added to the policy.
	11/19/2025 Minor Review. Facet Joint/medial branch block indication and codes are being moved to new policy MP 4.050.

MEDICAL POLICY

POLICY TITLE	EPIDURAL STEROID INJECTIONS FOR BACK PAIN
POLICY NUMBER	MP 4.014

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