



Proposed LCD: Epidural Procedures for Pain Management

Speaker
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Disclosures

- No relevant disclosures



COVERED INDICATIONS

#1: History, Physical Exam, Imaging to Support Radiculopathy or Neurogenic Claudication

- Radicular pain rather than radiculopathy
- Many patients have severe radicular pain w/o physical exam abnormalities. Neurological deficits are not common and are not necessary to support a dx of radicular pain.
- Straight leg raise is a specific test for radicular pain but it not very sensitive, thus it is often not present. Most important, patients with radicular pain who do not have a positive straight leg raise or neurologic deficits are just as likely to respond to epidural injections as those who do.

COVERED INDICATIONS

#1: History, Physical Exam, Imaging to Support Radiculopathy or Neurogenic Claudication

- Suggest rewording:
 - History and/or physical examination, and diagnostic imaging supporting one of the following:
 - Lumbar, cervical, or thoracic radicular pain
 - ...

COVERED INDICATIONS

#1: Requirement of 4 Weeks Pain Duration

- It is unrealistic to expect a patient with acute radicular pain from a disc herniation to delay an ESI. These are the patients most likely to benefit from the procedure.
- Suggest the following wording:
 - Pain duration of at least 4 weeks, with exception made for severe radicular pain where a 4-week delay cannot be tolerated...

COVERED INDICATIONS

#2: Requirement to Use Contrast

- Fully support use of contrast, except for patients with a documented contrast allergy or are pregnant.
- Suggest the following wording:
 - The ESIs must be performed under CT or fluoroscopic guidance with contrast, unless the patient has a documented contrast allergy or pregnancy. Ultrasound guidance without contrast may be considered in these and similar circumstances.

COVERED INDICATIONS

#5: Repeat Injections

- If after an initial injection, the patient's pain returns prior to 3 months, it is reasonable to attempt to reinstate relief with a repeat injection.
- If a 3-month threshold is required after an initial injection, a significant number of patients, who would otherwise obtain relief from a second injection, will proceed to surgery.

COVERED INDICATIONS

#5: Repeat Injections

Suggest the following wording:

- Repeat ESIs are appropriate when 1-2 prior ESIs provided prolonged reduction in radicular pain (i.e., 50% relief for at least 3 months) for the condition being treated. ESIs should not be repeated within 14 days. If a patient fails to respond well to a single ESI, a repeat ESI after 14 days can be performed using a different approach and/or medication, with the rationale and medical necessity for the second ESI documented in the medical record.

COVERED INDICATIONS

#6: ESI Injectant

- If the injections do not include steroid, they are not epidural “steroid” injections (ESIs), so suggest replacing “ESI injectant with epidural injectate.
- The current wording is confusing and stipulates that anti-inflammatories are required and contrast is not.
- Suggest the following wording:
 - The epidural injectate must include contrast agent unless the patients has a contraindication to contrast. Injectate may also include corticosteroids, local anesthetic, saline, and/or anti-inflammatories.

COVERED INDICATIONS

#7: Requirement of Other Conservative Treatment

- While some patients will certainly benefit from multimodal treatment, others who experience relief from an ESI may not require additional conservative treatment.
- We suggest rewording to indicate that ESIs *may be* performed in conjunction with conservative treatments.

COVERED INDICATIONS

New Indication - Diagnostic Spinal Nerve Block

- We suggest including the following:
 - Diagnostic spinal nerve blocks are performed by injecting anesthetics onto a single spinal nerve to help confirm or rule-out the source of the patient's pain, often to assist in surgical planning. These blocks utilize the same CPT codes as transforaminal ESIs (64479-64484) and should be allowed in patients that may have failed a therapeutic ESI when the medical necessity is documented in the medical records.

LIMITATIONS

- #1: Injections performed w/o image guidance or by ultrasound
 - Suggest allowing for ultrasound guidance in patients with documented contraindication to contrast media (e.g., allergy, pregnancy).
- #6: Limit to 4 ESIs per 12 Months
 - Suggest considering allowance of 3 ESIs per 6 months and 6 ESIs per 12 months, regardless of the number of levels involved

LIMITATIONS

- #11: Series of ESIs
 - While we do not support a “series of 3”, we do support repeat injections if previous injections were successful in achieving pain relief and functional improvement or only one prior injection was unsuccessful.
 - Suggest rewording as follows:
 - It is not medically reasonable and necessary to prescribe a predetermined series of ESIs.

LIMITATIONS

- #12: Steroid Dose
 - The dosages recommended are inaccurate. Data from studies looking at dosages implemented in transforaminal injections have been inappropriately extrapolated here to interlaminar injections.
 - Suggest rewording as follows to allow for slightly higher dosages, consistent with the previous version of the LCD:
 - Steroid dosing should be the lowest effective amount, not to exceed 80mg of triamcinolone, 80 mg of methylprednisolone, 12 mg of betamethasone, 15 mg of dexamethasone per session.

LIMITATIONS

- #13: Treatment exceeding 12 months
 - This limitation is unreasonable, and the requirements add a significant documentation burden to explain that a patient does not wish to proceed to surgery. We suggest omitting.
 - Requiring the pain physician to communicate with the primary care provider to discuss whether the patient is eligible for prolonged repeat steroid use places undue burden on physicians and should not be required.

PROVIDER QUALIFICATIONS

- Consider replacing “healthcare professionals” with “physicians”
- Physicians have the requisite training to:
 - accurately select patients
 - safely perform technically demanding procedures
 - immediately recognize, evaluate, and address potentially serious, life-altering complications

PROVIDER QUALIFICATIONS

We recommend the following language:

- Patient safety and quality of care mandate that healthcare professionals who perform epidural injection procedures for chronic pain (not surgical anesthesia) are appropriately trained by an accredited allopathic or osteopathic medical residency/fellowship program in an ABMS or an AOA accredited specialty whose core curriculum includes the performance and management of the procedures addressed in this policy. If the practitioner works in a hospital facility at any time and/or is credentialed by a hospital for any procedure, the practitioner must be credentialed to perform the same procedure in the outpatient setting. At a minimum, training must cover and develop an understanding of anatomy and drug pharmacodynamics and pharmacokinetics as well as proficiency in diagnosis and management of chronic pain related disease, the technical performance of the procedure, and utilization of the required associated imaging modalities.

SOCIETY GUIDANCE

- It should be noted that the North American Spine Society revised their coverage policy recommendations in 2020 and these should be reviewed and replace the 2013 and 2011 references listed on pages 25-26.³
- Please correct typos on the following society names:
 - American Society of Anesthesiologists
 - American Association of Neurological Surgeons and Congress of Neurological Surgeons
 - Spine Intervention Society

Thank you for the opportunity to make this presentation.

Questions?

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