Epidural Injections

Policy Number:	**M20130703049**
Effective Date:	**8/1/2013**
Sponsoring Department:	**Health Care Services**
Impacted Department(s):	**Health Care Services**

Type of Policy: ☒ Internal ☒ External

Data Classification: ☐Confidential ☐Restricted ☒Public

Applies to (Line of Business):

☐ Corporate (All)
☒ State Products, if yes which plan(s): ☒MediSource; ☒ MediSource Connect; ☐Child Health Plus; ☒ Essential Plan
☒ Medicare, if yes, which plan(s): ☒MAPD; ☐PDP; ☒ISNP; ☒CSNP
☒ Commercial, if yes, which type: ☒Large Group; ☒Small Group; ☒Individual
☒ Self-Funded Services *(Refer to specific Summary Plan Descriptions (SPDs) to determine any pre-authorization or pre-certification requirements and coverage limitations. In the event of any conflict between this policy and the SPD of a Self-Funded Plan, the SPD shall supersede the policy.)*

Excluded Products within the Selected Lines of Business (LOB)

N/A

Applicable to Vendors? Yes ☐ No☒

Purpose and Applicability:

To set forth the medical necessity criteria for epidural injections.

Policy:

Commercial and Self-Funded:

Epidural steroid injections may be considered medically necessary and a covered benefit when any of the following criteria are met:

Diagnostic injections are appropriate for these purposes:

- Differentiation of radicular from non-radicular pain;
- To evaluate a discrepancy between imaging studies and clinical findings;
- To identify the source of pain in the presence of multi-level nerve root compression;
- To identify the level of pathology at a previous operative site;
- To plan the level of injection for subsequent therapeutic injections.

Therapeutic injections are appropriate for these purposes:

- Radicular pain resistance to other therapeutic means or when surgery is contraindicated;
- Post-decompressive radiculitis or post-surgical scarring;
- Monoradicular pain confirmed by diagnostic blockade, in which a surgically correctable lesion cannot be identified;
- Treatment of acute herpes zoster or post-herpetic neuralgia;
- Spinal stenosis with neurogenic claudication.

Requirements for epidural injections (all required):

A. Prior to all procedures, documentation of an evaluation including history and physical examination by the provider;

B. Prior to the therapy, description of indications and medical necessity, as follows:
   1. Suspected organic problem
   2. Pain and disability of moderate-to-severe degree
   3. No evidence of contraindications. They include but are not limited to:
      - Severe spinal stenosis resulting in intraspinal obstruction
      - Predominantly psychogenic pain
      - Congenital anatomic anomalies or history of prior surgery in which the epidural space was absent, altered, or eliminated
      - Systemic infections or bleeding tendencies including anticoagulation therapy
      - Infection at the injection site
   4. Failure of responsiveness to conservative modalities of treatment, such as medications (analgesics, anti-inflammatory drugs, muscle relaxants), exercise and physical therapy, immobilization for 4 weeks.

C. Documentation of EITHER of the following studies performed within the prior 24 months:
   1. A concordant radiologist's interpretation of an advanced diagnostic imaging study (MRI or CT) of the spine demonstrating compression of the involved named spinal nerve root(s)
   2. Electrodiagnostic studies (EMG/NCVs) diagnostic of nerve root compression of the involved named spinal nerve root(s).

D. In all cases, assessment of this procedure outcome depends on the patient's responses and, therefore, documentation should also include:
    1. Whether the injection/block was a diagnostic or therapeutic injection
    2. Pre-and post-procedure evaluation of patient
    3. Education the member received.

E. Subsequent injections (both diagnostic and therapeutic) require the documentation of responsiveness to prior interventions.

F. The frequency and number of injections deemed appropriate are based on the indication:
    1. **Diagnostic:**
        - The frequency shall not be less than 2 weeks between injections during this phase
        - Once a diagnostic level has been successfully determined, all subsequent injections fall within the criteria of the therapeutic phase
    2. **Therapeutic (all criteria to be met):**
        - Injections may be repeated only upon return of pain +/- deterioration of functional status
        - Prior injections have resulted in "Significant pain relief" as defined below.

G. Continuation of injections beyond 12 months or more than 4 therapeutic injections per region is considered not medically necessary.

H. All transforaminal epidural injections are to be performed under fluoroscopic or CT-guided imaging as per the standard of care; it is encouraged that all other injections occur with the use of appropriate imaging.

I. In the case of blind interlaminar or caudal epidurals, subsequent injections are repeated only following a monitoring period of at least four weeks. Failure to obtain appropriate response may indicate improper delivery of the drug and/or presence of a pain generator. Subsequent epidural injections, therefore, should be performed with the aid of appropriate imaging. The imaging technique is at the discretion of the physician.

Investigational and Not Medically Necessary:
Epidural injections of corticosteroid preparations, with or without added anesthetic agents, are considered experimental and investigational for all other indications (e.g., non-specific low back pain [LBP] or "failed back syndrome," etc.) because their effectiveness for conditions other than allowed in policy is not yet established.

Medicare Advantage:
There is currently a Local Coverage Determination (LCD) for epidural injections. Please refer to the link listed in the Reference section for Medicare Advantage members.

MediSource, MediSource Connect, Child Health Plus and Essential Plan:
MediSource, MediSource Connect, Child Health Plus and Essential Plan cover epidural injections utilizing the Commercial and Self-Funded criteria above for all indications above except Low Back Pain. Per NYS Medicaid coverage criteria, MediSource, MediSource Connect, Child Health Plus and Essential Plan, systemic corticosteroids are not covered for the treatment of low back pain.

Pre-Authorization Required? Yes ☐ No ☒

Pre-authorization is not required at the present time. Claims are subject to review and may pend for clinical evaluation of medical necessity and may be denied. The criteria above will be utilized upon retrospective review.

Definitions

Epidural steroid injection (ESI) is a nonsurgical treatment for managing low back pain and sciatica caused by disc herniation or vertebral degenerative changes in order to relieve pain, improve function, and reduce the need for surgical intervention. There are three main approaches for ESI: caudal, interlaminar, and transforaminal, with the anatomical location chosen of the suspected pain generator. Interlaminar approaches deliver the injection fluid into the posterior epidural compartment, without the guarantee that it will flow to the anterior epidural compartment. During caudal injections, the needle is advanced through the sacrococcygeal ligament and sacral hiatus into the caudal epidural space, which communicates with the posterior lumbar epidural space. Transforaminal injections target the anterior epidural space and the spinal nerve as it exits the neural foramen. Fluoroscopic guidance includes the use of radiologic imaging to assist in the placement of instrumentation for invasive diagnostic and surgical procedures. ESI under fluoroscopic guidance is considered superior to blind ESIs in terms of accuracy of delivery of the treatment agents.

Significant pain relief is defined as greater than or equal to (> /=) 80%-90% initially with the ability to perform previously painful maneuvers, and persistent pain relief is defined as a minimum of six (6) weeks of >/= 50% relief with the continued ability to perform previously painful maneuvers.

Episode Treatment Period is defined as a twelve-month period from the initiation of injections.

References

Related Policies, Processes and Other Documents

Non-Regulatory references

Chou R, Loeser JD, Owens DK, et al.; American Pain Society Low Back Pain Guideline Panel. Interventional therapies, surgery, and interdisciplinary rehabilitation for low back pain: an evidence-based clinical practice guideline from the American Pain Society. Spine (Phila Pa 1976). 2009 May 1;34(10):1066-77.

Chou R, Cohen S. Subacute and chronic low back pain: Nonsurgical interventional treatment. In: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. (Accessed on June 17, 2026).

Cohen SP, Bicket MC, Jamison D, Wilkinson I, Rathmell JP. Epidural steroids: a comprehensive, evidence-based review. Reg Anesth Pain Med. 2013 May-Jun;38(3):175-200.

Henschke N, Maher CG, Ostelo RW, et al. Red flags to screen for malignancy in patients with low-back pain. Cochrane Database Syst Rev. 2013 Feb 28;(2):CD008686.

Maharty DC, Hines SC, Brown RB. Chronic Low Back Pain in Adults: Evaluation and Management. Am Fam Physician. 2024 Mar;109(3):233-244.

Symplr, Inc. Health Technology Assessment. Epidural Steroid Injections for Low Back Pain and Sciatica. Houston, TX. January 2013.

Regulatory References

Centers for Medicare and Medicaid Services (CMS) [web site]. Local Coverage Article: Billing and Coding: Epidural Steroid Injections for Pain Management (A58745). Available at: https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=58745&ver=20&bc=0 Accessed June 16, 2026.

Centers for Medicare and Medicaid Services (CMS) [web site]. Local Coverage Determination (LCD): Lumbar Epidural Injections (L39036). Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=39036&ver=23&keyword=L39036&keywordType=starts&areaId=s65&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance&bc=1 Accessed June 16, 2026.

DOH Medicaid Update November 2012 Vol. 28, No. 13 Medicaid Update for Low Back Pain Coverage Guidelines. Available at: https://www.health.ny.gov/health_care/medicaid/program/update/2012/2012-11.htm#low Accessed June 17, 2026.

New York State Department of Health [web site]. New York State Medicaid Program Physician Procedure Codes. Section 5- Surgery. Version April 2026 . Available at: https://www.emedny.org/ProviderManuals/Physician/PDFS/Physician%20Procedure%20Codes%20Sect5.pdf Accessed June 16, 2026.

This policy contains medical necessity criteria that apply for this service. Please note that payment for covered services is subject to eligibility criteria, contract exclusions and the limitations noted in the member's contract at the time the services are rendered.

Version Control

Signature / Approval on File? Yes ☒ No☐

Revision Date	Owner	Notes
8/1/2026	Health Care Services	Reviewed
9/1/2025	Health Care Services	Revised
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7/1/2023	Health Care Services	Revised
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10/1/2019	Medical Management	Revised
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