Local Coverage Determination (LCD): Pain Management (L33622)

**Contractor Information**

Contractor Name
National Government Services, Inc.

**LCD Information**

Document Information

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CMS National Coverage Policy

Language quoted from Centers for Medicare and Medicaid Services (CMS), National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See Section 1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, italicized text represents quotation from one or more of the following CMS sources:

**Title XVIII of the Social Security Act (SSA):**

Section 1862(a)(1)(A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

**Code of Federal Regulations:**

42 CFR, Section 410.32, indicates that diagnostic tests may only be ordered by the treating physician (or other treating practitioner acting within the scope of his or her license and Medicare requirements) who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician (or other qualified non-physician provider) who is treating the beneficiary are not reasonable and necessary (see Sec. 411.15(k)(1) of this chapter).

**CMS Publications:**

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15:

- 50 – 50.6 Drugs and Biologicals

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15:

- 80 Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests


- 30.3 Acupuncture
- 150.7 Prolotherapy, Joint Sclerotherapy, and Ligamentous Injections with Sclerosing Agents
Abstract:

Acute pain is elicited by the injury of body tissues and activation of nociceptive transducers at the site of local tissue damage. This type of pain is often a reason to seek health care, and it occurs after trauma, surgical interventions, and some disease processes.

Chronic pain has been defined as "persistent or episodic pain of duration or intensity that adversely affects the function or well-being of the patient, attributable to any nonmalignant etiology" ("Practice Guidelines for Chronic Pain Management: A Report by the American Society of Anesthesiologists Task Force on Pain Management, Chronic Pain Section"). In addition, the pain has been refractory to repeated attempts at medical management and usually has been present for at least three to six months.

Pain associated with cancer includes pain associated with disease progression as well as treatments. Pain associated with cancer can have multiple causes—namely, disease progression, treatment (e.g., neuropathic pain resulting from radiation therapy), and co-occurring diseases (e.g., arthritis). Regardless of whether the pain associated with cancer stems from disease progression, treatment, or a co-occurring disease, it may be either acute or chronic.

Spinal pain generates from multiple structures in the spine. Certain conditions may not be detectable using currently available technology or biochemical studies. However, for a structure to be implicated, it should have been shown to be a source of pain in patients, using diagnostic techniques of known reliability and validity. The structures responsible for pain in the spine, include but are not limited to, the vertebral bodies, intervertebral discs, spinal cord, nerve roots, facet joints, ligaments, muscles, atlanto-occipital joints, atlanto-axial joints, and sacroiliac joints.
Postlaminectomy syndrome or pain following operative procedures of the spine, sometimes known as failed management syndrome, is becoming an increasingly common entity in modern medicine. Other spinal conditions causing pain include various degenerative disorders such as spinal stenosis, spondylolysis, spondylolisthesis, degenerative scoliosis, idiopathic vertebrogenic sclerosis, diffuse idiopathic spinal hyperostosis, and segmental instability. Degenerative conditions other than disc disruption and facet arthritis may contribute to approximately 5% to 10% of spinal pain.

Neural blockade is one technique used in chronic pain management. Neural blockade is the interruption of neural transmission by the injection of a local anesthetic agent or other drug. Nerve block therapy can be used to answer specific questions resulting from a careful evaluation of the patient's pain problem and to gain insight into the underlying problem causing the pain. Success of the nerve block is determined by the adequacy of interruption of nerve function, and the effect of that blockade on the patient's pain. The goal of chronic pain management is to achieve optimal pain control, recognizing that a pain-free state may not be achievable; minimize adverse outcomes; enhance functional abilities and physical and psychological well-being; and enhance the quality of life for patients with chronic pain.

The decision to treat chronic pain by invasive or destructive procedures must be based on a thorough evaluation of the patient and include a systematic assessment of the location, intensity, and pathophysiology of the pain. A detailed pain history that includes prior treatment and response to treatment is essential. A detailed physical examination and review of all pertinent diagnostic tests is also needed. This local coverage determination documents National Government Services indications and limitations for pain management treatment.

For complete coverage detail, please review each of the following sections: Indications and Limitations for Specific Types of Injections, Limitations for All Diagnostic and Therapeutic Pain Management Services, Documentation Requirements and Utilization Guidelines.

**Indications and Limitations for Specific Types of Injections**

**TRIGGER POINT INJECTIONS**

Trigger point injection is one of the many modalities utilized in the management of chronic pain. Myofascial trigger points are self-sustaining hyperirritative foci that may occur in any skeletal muscle in response to strain produced by acute or chronic overload. These trigger points produce a referred pain pattern characteristic for that individual muscle. Production of a referred pain pattern differentiates myofascial pain syndrome from tender points and fibromyalgia. Each pattern becomes part of a single muscle myofascial pain syndrome (MPS); and each of these single muscle syndromes is responsive to appropriate treatment, which includes injection therapy. Injection is achieved with needle insertion and the administration of agents such as local anesthetics.

**Indications:**

The diagnosis of trigger points requires a detailed history and thorough physical examination.
The following clinical features are present most consistently, and are helpful in making the diagnosis:

- History of onset of the painful condition, and its presumed cause (injury, sprain, etc.);
- Distribution pattern of pain consistent with the referral pattern of the trigger points;
- Restriction of range of motion with increased sensitivity to stretch;
- Muscular deconditioning in the affected area;
- Focal tenderness of a trigger point;
- Palpable taut band of muscle in which trigger point is located;
- Local taut response to snapping palpation or needle insertion; and
- Reproduction of referred pain pattern upon stimulation of the trigger point.

The goal is to treat the cause of the pain and not just the symptom of pain. Other treatment modalities include:

- Pharmacologic treatment including analgesics and medications to induce sleep and relax muscles (i.e. antidepressants, neuroleptics, or non steroidal anti-inflammatory drugs); and
- Nonpharmacologic treatment modalities (i.e., osteopathic manual medicine techniques, massage, ultrasonography, application of heat or ice, transcutaneous electrical nerve stimulation, Spray and Stretch technique); and
- For trigger points in the acute state of formation (before additional pathologic changes develop), effective treatment may be delivered through physical therapy.

After myofascial pain syndrome is established as described above, trigger point injection may be indicated when noninvasive medical management is not successful or as first line treatment. Additionally, trigger point injection is indicated when the movement of a joint is mechanically blocked as is the case of the coccygeus muscle.

**Limitations:**

Only one trigger point injection procedure (CPT codes 20552 or 20553) should be reported on any particular day, no matter how many sites or regions are injected.

The local anesthetic administered in conjunction with trigger point injections is included in the practice expense for these procedures.

Trigger point injections used on a routine basis, e.g., on a regular periodic and continuous basis, for patients with chronic non-malignant pain syndromes are not considered medically necessary.

Only injections of local anesthetics and corticosteroids are covered. Injections consisting of only saline and/or botanical substances are not supported in the peer-reviewed literature and are not considered medically necessary.

**INJECTION OF TENDON SHEATHS, LIGAMENTS, GANGLION CYSTS, CARPAL AND TARSAL TUNNELS**
Injection into tendon sheaths, ligaments, ganglion cysts, tarsal or carpal tunnel is sometimes indicated to provide relief of pain and to reduce the inflammation in these structures when response to conservative measures has failed or is not indicated.

For the purposes of clarity the following descriptions are offered for each term:

**Ligament** - A band of tissue that connects bones.

**Tendon** - A fibrous cord of connective tissue attaching a muscle to a bone or other structure. A tendon sheath is the lining enclosing a tendon. It facilitates movement around the tendon.

**Ganglion cyst** - These knot like masses are non-cancerous and fluid filled cysts that arise from the ligaments, joint linings, or tendon sheaths.

**Carpal tunnel** - This is a passageway that runs from the forearm through the wrist. The median nerve and nine tendons pass through the tunnel.

**Tarsal tunnel** - A passageway on the medial side of the tarsus. The posterior tibial nerve passes through the tunnel.

**Indications for Tendon Sheath, Ligament, Ganglion Cysts, Carpal and Tarsal Tunnel Injections:**

Injection into tendon sheaths, their origins or insertions, ligaments, or ganglion cysts is indicated to relieve substantial pain and/or significant functional disability that results from inflammation or other pathological changes in those structures. Proper use of this modality should be part of an overall management plan including diagnostic evaluation in order to clearly identify and properly treat the primary cause.

Other conservative therapy has not provided acceptable relief, is contraindicated, or not appropriate.

There is a reasonable likelihood that injection will significantly improve the patient's pain and/or functional disability.

Injection of a carpal tunnel may be indicated for the patient with mild to moderate symptoms when pharmaceutical and other conservative measures have failed or are not otherwise indicated.

Injection of the tarsal tunnel may be indicated for conservative management of tarsal tunnel syndrome.

**Limitations for Tendon Sheath, Ligament, Ganglion Cysts, Carpal and Tarsal Tunnel Injections:**

When a given specific tendon, ligament, tunnel, or cyst is injected, it will be considered one injection service regardless of the number of injections administered at that specific anatomical
Epidural and intrathecal (epidural and subarachnoid) injections are utilized for acute and chronic pain, cancer pain management, and treatment of spasticity. Epidural and intrathecal injections are utilized both for diagnostic and therapeutic purposes.

Indications for Diagnostic and Therapeutic Epidural and Intrathecal Injections:

Diagnostic interlaminar/translaminar or caudal epidural steroid injections are seldom used. Although the medication injected can sometimes be confined to a limited area, bilateral effects and spread of injectate to adjacent levels often occurs. Diagnostic injections can easily be performed with transforaminal epidural injections if meticulous technique and a low volume of injectate are used. For diagnostic purposes, a transforaminal epidural injection is performed with meticulous technique and low volume of injected local anesthetic.

Intrathecal diagnostic injections are also used to determine the dose of opioid for pain control, or that no opioid will be effective in any dose, as well as to determine a patient's response to baclofen, clonidine, local anesthetic, and other medications.

Therapeutic intrathecal (subarachnoid) injections and infusions of opioid, local anesthetic, clonidine, and other medications may be used for the treatment of acute or chronic pain, cancer pain, and baclofen for intractable spasticity. Both epidural and intrathecal injections may be used for the following:

- Acute obstetric, post-traumatic and post-operative pain;
- Advanced cancer pain, primary or metastatic;
- Acute/sub-acute pain syndromes including cervical/thoracic and lumbar pain with radiculopathy and intervertebral disc disease (with neuritis or radiculitis), with or without myelopathy, that has failed to respond to adequate conservative management;
- Nerve root injuries and neuropathic pain, post-surgery and post-traumatic, including post-laminectomy syndrome (failed back syndrome);
- Spinal cord myelopathy;
- Complex regional pain syndrome;
- Epidural scarring from prior infection, hemorrhage, and/or surgery
- Multiple rib fractures;
- Vertebral compression fractures;
- Post-herpetic neuralgia and herpes zoster;
- Phantom limb pain; and
- Management of intractable spasticity that has failed medical treatment with oral antispasmodics.
The medical record should describe the presence of radicular pain or discogenic pain and the neuropathic diagnosis for the pain being treated. In addition, the medical record should indicate one or more of the following:

- Conservative management has failed unless the patient has acute disabling and debilitating pain;
- The patient is a candidate for surgery, but surgery is unacceptable to the patient or the patient is a poor surgical risk; and/or
- The epidural injection is being performed as a therapeutic adjunct to a conservative therapy program, to provide temporary relief and in order to facilitate a more aggressive rehabilitative program.

**EPIDURAL INJECTIONS - TRANSFORAMINAL**

**Indications for Transforaminal Epidural Injections:**

Transforaminal epidural injection is a selective block of the cervical/thoracic, lumbar, or sacral nerve roots with proximal spread of contrast/local anesthetic through the neural foramen to the epidural space. With the aid of fluoroscopic or computed tomography (CT) imaging, the needle tip is placed within or adjacent to the lateral margin of a neural foramen, and contrast material is injected to obtain a neurogram and visualize spread of the injected solution. A small volume of local anesthetic is injected (less than or equal to 1.0 ml) in order to perform a diagnostic, reproducible blockade of a specific nerve root. The diagnostic usefulness is lost if more than 1.0 ml of injectate is injected (the block becomes unreliable, since spread of anesthetic to adjacent levels and structures likely occurs). A steroid can be added as a therapeutic measure. Injections for therapeutic reasons can be of greater volume. The block can be performed for diagnostic, therapeutic, or both purposes.

Transforaminal epidural injections are appropriate for the following diagnostic purposes:

- To differentiate the level of radicular nerve root pain;
- To differentiate 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; and/or
- To identify the level of pathology at a previous operative site.

It might be necessary to perform injections at two (2) different nerve root levels on the same date of service, whether injected unilaterally or bilaterally, if multi-level nerve root compression or stenosis is present on imaging studies and documented in the medical record, and suspected to be responsible for the patient’s symptoms and findings.

Transforaminal epidural injections are appropriate for the following therapeutic purposes:

- Radicular pain resistant 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; and/or
• Treatment of acute herpes zoster or post-herpetic neuralgia.

PARAVERTEBRAL JOINT/NERVE BLOCKS – DIAGNOSTIC AND THERAPEUTIC

The facet, or zygapophysial, joints are paired diarthrodial articulations between posterior elements of adjacent vertebrae. Spinal facet joints have been implicated as responsible for spinal pain in 15% to 45% of patients with low back pain, 36% to 67% of patients with neck pain, and 34% to 48% of patients with thoracic pain (Boswell et al, 2007). Paravertebral facet joint/nerve block is utilized as a diagnostic tool to determine whether a specific facet joint is responsible for chronic spinal pain. The patient with this condition usually has moderate-to-severe back pain that does not have a strong radicular component, there is no associated neurologic deficit, the pain is typically aggravated by hyperextension of the spine, and there is typically tenderness to palpation of the spine at the level of the suspected joint. Back or neck pain is typically worse than leg or arm pain, respectively, e.g., pain is primarily axial, not radicular.

Facet joint arthropathy (joint disease) is diagnosed through a double-comparative local anesthetic blockade of a joint, either by intra-articular injection of a small volume of local anesthetic (0.5 to 1.0 ml), or blockade of the medial branch nerves of the dorsal rami innervating the joint with a small volume of local anesthetic (0.5 to 1.0 ml). A single block has been implicated to be a source of false-positive results in 27% to 63% of patients in the cervical spine, 42% to 58% of the patients in the thoracic spine, and 17% to 47% in the lumbar spine (Sehgal et al, 2007). The diagnosis can be made by a positive but differential response to local anesthetics of different durations of action injected on separate occasions.

After a needle is placed into the facet joint or adjacent to the target medial branch nerve under fluoroscopic or computed tomography (CT) imaging guidance, a small volume (0.5 to 1.0 ml) of a short or long-acting local anesthetic agent with or without steroid is injected. The patient is then asked to engage in activities that typically elicit or aggravate the pain. Relief of pain for a significant period of time suggests that facet joints were the source of the pain. Pre-procedural and post-procedural pain scores (numeric or Visual Analogue) should be documented, and then compared. If significant pain relief occurs after the injection (a positive response), the patient’s response should be monitored and documented with regards to the degree of pain relief, duration of pain relief, and improvement in functional status. A repeat block may be performed only if the patient’s pain returns and functional status starts to deteriorate. If significant relief is noted with improvement in functional status, but the pain returns after a period of relief, a second block may be performed at a later date with local anesthetic of a different duration of action in order to rule out a false-positive response.

If double-comparative paravertebral facet joint /nerve blocks provide significant pain relief lasting several weeks to months, therapeutic facet joint/nerve blocks may be considered. If double-comparative paravertebral facet joint/nerve blocks provide significant pain relief that is not long-lasting, facet joint denervation may be considered.

Indications for Paravertebral Facet Joint/Nerve Block:
Diagnostic or therapeutic injections/nerve blocks may be required for the management of chronic pain. It may take multiple nerve blocks targeting different anatomic structures to establish the etiology of the chronic pain in a given patient. It is standard medical practice to use the modality most likely to establish the diagnosis or treat the presumptive diagnosis. If the first set of procedures fails to produce the desired effect or to rule out the diagnosis, the provider should then proceed to the next logical test or treatment indicated. For the purpose of this paravertebral facet joint block LCD, an anatomic region is defined per CPT as cervical/thoracic (64490, 64491, 64492) or lumbar/sacral (64493, 64494, 64495).

Fluoroscopic or computed tomography (CT) image guidance and localization are required for the performance of paravertebral facet joint injections described by codes 64490-64495. For Paravertebral Spinal Nerves and Branches – Image guidance [fluoroscopy or CT] and any injection of contrast are inclusive components of 64490-64495.

**Diagnostic Paravertebral Facet Joint/Nerve Block**

Diagnostic paravertebral facet joint/nerve block is appropriate for the following conditions:

- Hypertrophic arthropathy of the facet joints causing back and/or neck pain;
- Back or neck pain following whiplash/post-traumatic injury;
- Back pain greater than leg pain;
- Neck pain greater than arm pain;
- Thoracic pain greater than chest wall pain;
- Back or neck pain associated with suspected motion segment instability/hypermobility or pseudoarthrosis following fusion; and/or

Repeat injection would be considered medically necessary only upon subsequent return of pain and deterioration in functional status. As noted in the above, if pain returns after a satisfactory response it may be necessary to give a second injection on a different date of service to determine the etiology of the pain and effectiveness of the injection. Two-to-three adjacent joint levels may need to be injected before the level(s) is (are) determined.

**Therapeutic Paravertebral Facet Joint/Nerve Block**

When a patient has relief of pain with controlled diagnostic blocks with a combined response from two blocks of several weeks to months, he/she may be considered a candidate for therapeutic facet joint/nerve nerve blocks. When a patient has relief of pain (positive response), but an insufficient duration of symptom relief, with controlled diagnostic blocks, he/she should be considered for a more definitive procedure such as denervation unless, of course, the diagnosis is in error.

Therapeutic facet joint/nerve block injections may be considered provided that:

- injections do not exceed a frequency parameter of more than once every two (2) months for a specific region (cervical/thoracic, lumbosacral);
• initial pain relief of greater than or equal to (> /=) 80%-90% with the ability to perform previously painful maneuvers and persistent pain relief for a minimum of six (6) weeks of >/=50% with the continued ability to perform previously painful maneuvers; and
• appropriate consideration is given to the adverse effects (e.g., adrenal suppression of corticosteroid injections).

PARAVERTEBRAL JOINT/NERVE DENERVATION

Paravertebral facet joint denervation is the destruction of a paravertebral facet joint nerve by neurolytic agent (e.g., chemical, thermal, electrical, radiofrequency). Facet joint denervation may be considered if double-comparative paravertebral facet joint/nerve blocks do provide significant pain relief, but the pain relief is not long-lasting. This procedure involves placing a needle or radiofrequency cannula adjacent to each of the two, or more, medial branch nerves innervating the target joint(s).

Indications for Paravertebral Joint/Nerve Denervation:

Facet joint arthropathy (joint disease) is diagnosed through a double-comparative local anesthetic blockade as described above.

For those beneficiaries that are considered candidates for denervation, the medical record should reflect the failure of conservative therapy and that appropriate diagnostic paravertebral facet joint/nerve block studies have been performed. Studies should document the specific joint level(s) affected and that significant, but not long-lasting, pain relief has been obtained from the paravertebral facet joint/nerve blocks. Significant pain relief in this instance is defined as greater than or equal to (> /=) 80%-90% initially with the ability to perform previously painful maneuvers.

Limitations for Paravertebral Joint/Nerve Denervation:

The effects of denervation should last from six (6) months to one (1) year, or longer. In some instances, though, the effects may be permanent. Repeat denervation procedures at the same joint/nerve level will only be considered medically necessary when the patient had significant improvement of pain after the initial facet joint nerve destruction that lasted an appropriate period of time (greater than or equal to six months).

Pulsed radiofrequency for denervation is considered investigational and thus, not medically necessary.

SACROILIAC (SI) JOINT INJECTIONS

The sacroiliac (SI) joint is a diarthrodial, synovial joint which is formed by the articular surfaces of the sacrum and iliac bones. The SI joints bear the weight of the trunk and as a result are subject to the development of strain and/or pain.

Indications for Sacroiliac (SI) Joint Injections:
Sacroiliac (SI) joint injections would be considered medically reasonable and necessary for the diagnosis and/or treatment of chronic low back pain that is considered to be secondary to suspected sacroiliac joint dysfunction. Diagnostic and therapeutic injections of the SI joint would not likely be performed unless conservative therapy and noninvasive treatments (i.e., rest, physical therapy, NSAIDs, etc.) have failed.

Diagnostic blocks of a sacroiliac joint can be performed to determine whether it is the source of low back pain. Arthropathy (joint disease) is diagnosed through a double-comparative local anesthetic blockade of the joint by the intra-articular injection of a small volume of local anesthetics (2 to 3 ml) of different durations of actions. A positive response should demonstrate initial pain relief greater than or equal to (≥ 80%-90%) and the ability to perform previously painful maneuvers. Steroids may be injected in addition to the local anesthetic.

Therapeutic sacroiliac (SI) joint injections of an anesthetic and/or steroid to block the joint for immediate, and potentially long lasting, pain relief are considered medically reasonable and necessary if it is determined that the SI joint is the source of pain in the lower back. The local anesthetic used for the procedure should not be billed.

SI joint arthrography and/or therapeutic injection of an anesthetic/steroid should only be reported when imaging confirmation of intra-articular needle positioning with applicable radiological and/or fluoroscopic procedures have been performed.

Limitations for Sacroiliac (SI) Joint Injections:

If previous diagnostic or therapeutic SI injections of an anesthetic and/or steroid to block the joint for immediate, and potentially long lasting, pain relief have not effectively relieved the pain, further injections would not be considered medically necessary.

LIMITATIONS FOR ALL DIAGNOSTIC AND THERAPEUTIC PAIN MANAGEMENT SERVICES

Low back pain may also be associated with “myofascial pain syndrome” or a soft-tissue source of pain in which case no nerve root pathology exists, so interlaminar/translaminar, caudal, or transforaminal epidural injection would be ineffective. If the diagnosis is in question, the diagnosis of radiculopathy should be confirmed by electrophysiological studies, radiological studies, or a diagnostic transforaminal selective epidural/selective nerve root injection. A paravertebral joint/nerve or sacroiliac joint injection would also not be indicated for pain associated with “myofascial pain syndrome.”

Nerve blocks may be used for diagnostic and therapeutic purposes. Therapeutic blocks include the use of anesthetic, antispasmodic, and/or anti-inflammatory substances for the long-term control of pain. There is no role for a "series" of injections. Each injection should be individually evaluated for clinical efficacy (diagnostically and/or therapeutically). If complete, but only temporary pain relief occurs after the injections, another type of treatment needs to be considered.
Other interventional pain management procedures done on the same day as paravertebral facet joint blocks should be rare. In certain circumstances a patient may present with both facet and sacroiliac problems. In this case, it is appropriate to perform both facet injections and SI injection at the same session assuming that these are therapeutic injections and that prior diagnostic injections (blocks) have demonstrated that both structures contribute to pain generation. The medical record must clearly support both procedures. Medicare recognizes that this is not common and will monitor the frequency with which these codes are combined. Multiple procedure modifiers will apply to intraarticular sacroiliac injection.

It is usually not appropriate to provide an interlaminar epidural/intrathecal injection, a transforaminal selective epidural (or selective nerve root injection), facet joint/nerve block, sacroiliac joint injection, lumbar sympathetic block, or other nerve block on the same day. Therefore, only one of these procedures is allowed on a given day, unless conditions are met as described immediately above for paravertebral and sacroiliac joints or one of the following conditions occur and are documented in the medical record.

- If more than one type of diagnostic injection is performed on the same day, the anesthetic response to the first injection must be assessed and demonstrate incomplete pain relief prior to proceeding with the additional injection. Otherwise it would be impossible to determine which injection resulted in pain relief.
- Multiple pain generators are present and are clearly documented in a patient on anticoagulants, requiring the anticoagulants to be stopped for the injection(s).

Epidural steroids should be used only in the presence of radiculopathy unless the pain is discogenic in origin.

The standard of care for all transforaminal epidural injections, for paravertebral facet joint/nerve injection and denervation, and sacroiliac joint injections requires that these procedures be performed under fluoroscopic- or CT-guided imaging. Therefore, injections performed without imaging guidance will be considered inappropriate and not reasonable or necessary. The rationale for accepted medically necessary use of CT rather than fluoroscopy must be documented.

Failure to obtain appropriate response to blind interlaminar or caudal epidurals may indicate improper delivery of the drug and/or presence of a pain generator, which is non-responsive to epidural injection. Thus, subsequent epidural injections after a failed or inadequate response, if performed, should be under fluoroscopic visualization.

General anesthesia or monitored anesthesia care (MAC) is rarely, if ever required for injections addressed in this policy. In fact, general anesthesia is contraindicated for diagnostic blocks (Manchikanti et al, 2005). Further, monitored anesthesia care or heavy sedation may provide false-positive results.

CPT code 72275 (Epidurography, radiological supervision and interpretation) represents a formal recorded and reported contrast study that includes fluoroscopy. Epidurography should
only be reported when it is reasonable and medically necessary to perform a diagnostic study. It may only be performed with a caudal or intrathecal approach and should not be billed for the usual work of fluoroscopy and dye injection that is integral to the epidural, paravertebral joint/nerve, or sacroiliac injection(s).

*Until the pending scientific assessment of the technique has been completed and its efficacy has been established, Medicare reimbursement for acupuncture, as an anesthetic or as an analgesic or for other therapeutic purposes, may not be made. Accordingly, acupuncture is not considered reasonable and necessary within the meaning of §1862(a)(1) of the Act.* (CMS Publication 100-03, *Medicare National Coverage Determinations (NCD) Manual*, Chapter 1: Section 30.3)

The medical effectiveness of Prolotherapy, Joint Sclerotherapy, and Ligamentous Injections with Sclerosing Agents has not been verified by scientifically controlled studies. Accordingly, reimbursement for these modalities should be denied on the ground that they are not reasonable and necessary as required by §1862(a)(1) of the Act. (CMS Publication 100-03, *Medicare National Coverage Determinations (NCD) Manual*, Chapter 1: Section 150.7)

CMS Publication 100-08, *Program Integrity Manual*, Chapter 13, section 5.1 outlines that “reasonable and necessary” services are “ordered and /or furnished by qualified personnel.” Services will be considered medically reasonable and necessary only if performed by appropriately trained providers. Training and expertise must have been acquired within the framework of an accredited residency and/or fellowship program in the applicable specialty/subspecialty. If this skill has been acquired as continuing medical education, the courses must be comprehensive, offered, sponsored or endorsed by an academic institution in the United States and/or by the applicable specialty/subspecialty society in the United States, and designated by the American Medical Association (AMA) as Category 1 Credit. Documentation of training must be available upon request.

Non-physician practitioners (NPPs) may only perform procedures requiring radiologic imaging if their respective states allow such in their practice act and license the practitioner to use radiation.

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**Coding Information**

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.
Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

Revenue codes only apply to providers who bill these services to the Part A MAC Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the Part B MAC.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

All revenue codes billed on the inpatient claim for the dates of service in question may be subject to review.

CPT/HCPCS Codes
Group 1 Paragraph: TRIGGER POINT INJECTIONS

Group 1 Codes:

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)

Group 2 Paragraph: INJECTION OF TENDON SHEATHS, LIGAMENTS, GANGLION CYSTS, CARPAL AND TARSAL TUNNELS

Group 2 Codes:

20526 INJECTION, THERAPEUTIC (EG, LOCAL ANESTHETIC, CORTICOSTEROID), CARPAL TUNNEL
20550 INJECTION(S); SINGLE TENDON SHEATH, OR LIGAMENT, APONEUROSIS (EG, PLANTAR "FASCIA")
20551 INJECTION(S); SINGLE TENDON ORIGIN/INSERTION
20612 ASPIRATION AND/OR INJECTION OF GANGLION CYST(S) ANY LOCATION
28899 UNLISTED PROCEDURE, FOOT OR TOES

Group 3 Paragraph: EPIDURAL AND INTRATHECAL INJECTIONS - INTERLAMINAR AND CAUDAL

Group 3 Codes:

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)
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

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)

**Group 4 Paragraph: INTRATHECAL BACLOFEN ADMINISTRATION**

**Group 4 Codes:**

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

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)

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

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)

J0475 INJECTION, BACLOFEN, 10 MG
J0476 INJECTION, BACLOFEN, 50 MCG FOR INTRATHECAL TRIAL
**Group 5 Paragraph: EPIDURAL INJECTIONS – TRANSFORAMINAL**

**Group 5 Codes:**

- INJECTION(S), ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); CERVICAL OR THORACIC, SINGLE LEVEL
- 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)
- INJECTION(S), ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); LUMBAR OR SACRAL, SINGLE LEVEL
- 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)

**Group 6 Paragraph: PARAVERTEBRAL JOINT/NERVE BLOCKS (DIAGNOSTIC AND THERAPEUTIC) and PARAVERTEBRAL JOINT/NERVE DENERVATION**

**Group 6 Codes:**

- 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
- 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)
- 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)
- 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
- 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)
INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT)
64495 WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL; THIRD AND ANY ADDITIONAL LEVEL(S) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT
64633 NERVE(S), WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); CERVICAL OR THORACIC, SINGLE FACET JOINT
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)
DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT
64635 NERVE(S), WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); LUMBAR OR SACRAL, SINGLE FACET JOINT
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)
64999 UNLISTED PROCEDURE, NERVOUS SYSTEM

Group 7 Paragraph: SACROILIAC (SI) JOINT INJECTIONS

Group 7 Codes:

INJECTION PROCEDURE FOR SACROILIAC JOINT, ANESTHETIC/STEROID, 27096 WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT) INCLUDING ARTHROGRAPHY WHEN PERFORMED
INJECTION PROCEDURE FOR SACROILIAC JOINT; PROVISION OF G0260 ANESTHETIC, STEROID AND/OR OTHER THERAPEUTIC AGENT, WITH OR WITHOUT ARTHROGRAPHY

ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph: The use of an ICD-10-CM code does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination.
TRIGGER POINT INJECTIONS (CPT codes 20552 and 20553)

**Group 1 Codes:**

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M60.9</td>
<td>Myositis, unspecified</td>
</tr>
<tr>
<td>M79.1</td>
<td>Myalgia</td>
</tr>
</tbody>
</table>

**Group 2 Paragraph:** INJECTION OF TENDON SHEATHS, LIGAMENTS, GANGLION CYSTS, CARPAL AND TARSAL TUNNELS (CPT codes 20526, 20550, 20551, 20612, 28899 [use for tarsal tunnel injections])

**Group 2 Codes:**

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D48.1</td>
<td>Neoplasm of uncertain behavior of connective and other soft tissue</td>
</tr>
<tr>
<td>G56.01</td>
<td>Carpal tunnel syndrome, right upper limb</td>
</tr>
<tr>
<td>G56.02</td>
<td>Carpal tunnel syndrome, left upper limb</td>
</tr>
<tr>
<td>G57.51</td>
<td>Tarsal tunnel syndrome, right lower limb</td>
</tr>
<tr>
<td>G57.52</td>
<td>Tarsal tunnel syndrome, left lower limb</td>
</tr>
<tr>
<td>M20.10</td>
<td>Hallux valgus (acquired), unspecified foot</td>
</tr>
<tr>
<td>M25.711</td>
<td>Osteophyte, right shoulder</td>
</tr>
<tr>
<td>M25.712</td>
<td>Osteophyte, left shoulder</td>
</tr>
<tr>
<td>M25.721</td>
<td>Osteophyte, right elbow</td>
</tr>
<tr>
<td>M25.722</td>
<td>Osteophyte, left elbow</td>
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<tr>
<td>M25.731</td>
<td>Osteophyte, right wrist</td>
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<td>M25.732</td>
<td>Osteophyte, left wrist</td>
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<tr>
<td>M25.741</td>
<td>Osteophyte, right hand</td>
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<td>M25.742</td>
<td>Osteophyte, left hand</td>
</tr>
<tr>
<td>M25.751</td>
<td>Osteophyte, right hip</td>
</tr>
<tr>
<td>M25.752</td>
<td>Osteophyte, left hip</td>
</tr>
<tr>
<td>M25.761</td>
<td>Osteophyte, right knee</td>
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<tr>
<td>M25.762</td>
<td>Osteophyte, left knee</td>
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<tr>
<td>M25.771</td>
<td>Osteophyte, right ankle</td>
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<tr>
<td>M25.772</td>
<td>Osteophyte, left ankle</td>
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<tr>
<td>M25.774</td>
<td>Osteophyte, right foot</td>
</tr>
<tr>
<td>M25.775</td>
<td>Osteophyte, left foot</td>
</tr>
<tr>
<td>M46.01</td>
<td>Spinal enthesopathy, occipito-atlanto-axial region</td>
</tr>
<tr>
<td>M46.02</td>
<td>Spinal enthesopathy, cervical region</td>
</tr>
</tbody>
</table>
M46.03  Spinal enthesopathy, cervicothoracic region
M46.04  Spinal enthesopathy, thoracic region
M46.05  Spinal enthesopathy, thoracolumbar region
M46.06  Spinal enthesopathy, lumbar region
M46.07  Spinal enthesopathy, lumbosacral region
M46.08  Spinal enthesopathy, sacral and sacroccygeal region
M46.09  Spinal enthesopathy, multiple sites in spine
M65.111 Other infective (teno)synovitis, right shoulder
M65.112 Other infective (teno)synovitis, left shoulder
M65.121 Other infective (teno)synovitis, right elbow
M65.122 Other infective (teno)synovitis, left elbow
M65.131 Other infective (teno)synovitis, right wrist
M65.132 Other infective (teno)synovitis, left wrist
M65.141 Other infective (teno)synovitis, right hand
M65.142 Other infective (teno)synovitis, left hand
M65.151 Other infective (teno)synovitis, right hip
M65.152 Other infective (teno)synovitis, left hip
M65.161 Other infective (teno)synovitis, right knee
M65.162 Other infective (teno)synovitis, left knee
M65.171 Other infective (teno)synovitis, right ankle and foot
M65.172 Other infective (teno)synovitis, left ankle and foot
M65.18 Other infective (teno)synovitis, other site
M65.19 Other infective (teno)synovitis, multiple sites
M65.311 Trigger thumb, right thumb
M65.312 Trigger thumb, left thumb
M65.321 Trigger finger, right index finger
M65.322 Trigger finger, left index finger
M65.331 Trigger finger, right middle finger
M65.332 Trigger finger, left middle finger
M65.341 Trigger finger, right ring finger
M65.342 Trigger finger, left ring finger
M65.351 Trigger finger, right little finger
M65.352 Trigger finger, left little finger
M65.4  Radial styloid tenosynovitis [de Quervain]
M65.80 Other synovitis and tenosynovitis, unspecified site
M65.811 Other synovitis and tenosynovitis, right shoulder
M65.812 Other synovitis and tenosynovitis, left shoulder
M65.821 Other synovitis and tenosynovitis, right upper arm
M65.822 Other synovitis and tenosynovitis, left upper arm
M65.831 Other synovitis and tenosynovitis, right forearm
M65.832 Other synovitis and tenosynovitis, left forearm
M65.841 Other synovitis and tenosynovitis, right hand
M65.842 Other synovitis and tenosynovitis, left hand
M65.851 Other synovitis and tenosynovitis, right thigh
M65.852 Other synovitis and tenosynovitis, left thigh
M65.861 Other synovitis and tenosynovitis, right lower leg
M65.862 Other synovitis and tenosynovitis, left lower leg
M65.871 Other synovitis and tenosynovitis, right ankle and foot
M65.872 Other synovitis and tenosynovitis, left ankle and foot
M65.88 Other synovitis and tenosynovitis, other site
M65.89 Other synovitis and tenosynovitis, multiple sites
M65.9 Synovitis and tenosynovitis, unspecified
M66.211 Spontaneous rupture of extensor tendons, right shoulder
M66.212 Spontaneous rupture of extensor tendons, left shoulder
M66.811 Spontaneous rupture of other tendons, right shoulder
M66.812 Spontaneous rupture of other tendons, left shoulder
M67.311 Transient synovitis, right shoulder
M67.312 Transient synovitis, left shoulder
M67.321 Transient synovitis, right elbow
M67.322 Transient synovitis, left elbow
M67.331 Transient synovitis, right wrist
M67.332 Transient synovitis, left wrist
M67.341 Transient synovitis, right hand
M67.342 Transient synovitis, left hand
M67.351 Transient synovitis, right hip
M67.352 Transient synovitis, left hip
M67.361 Transient synovitis, right knee
M67.362 Transient synovitis, left knee
M67.371 Transient synovitis, right ankle and foot
M67.372 Transient synovitis, left ankle and foot
M67.38 Transient synovitis, other site
M67.39 Transient synovitis, multiple sites
M67.40 Ganglion, unspecified site
M67.411 Ganglion, right shoulder
M67.412 Ganglion, left shoulder
M67.421 Ganglion, right elbow
M67.422 Ganglion, left elbow
M67.431 Ganglion, right wrist
M67.432 Ganglion, left wrist
M67.441 Ganglion, right hand
M67.442 Ganglion, left hand
M67.451 Ganglion, right hip
M67.452 Ganglion, left hip
M67.461 Ganglion, right knee
M67.462 Ganglion, left knee
M67.471 Ganglion, right ankle and foot
M67.472 Ganglion, left ankle and foot
M67.48 Ganglion, other site
M67.49 Ganglion, multiple sites
M70.031 Crepitant synovitis (acute) (chronic), right wrist
M70.032 Crepitant synovitis (acute) (chronic), left wrist
M70.041 Crepitant synovitis (acute) (chronic), right hand
M70.042 Crepitant synovitis (acute) (chronic), left hand
M70.10 Bursitis, unspecified hand
M70.11 Bursitis, right hand
M70.12 Bursitis, left hand
M70.21 Olecranon bursitis, right elbow
M70.22 Olecranon bursitis, left elbow
M70.31 Other bursitis of elbow, right elbow
M70.32 Other bursitis of elbow, left elbow
M70.41 Prepatellar bursitis, right knee
M70.42 Prepatellar bursitis, left knee
M70.51 Other bursitis of knee, right knee
M70.52 Other bursitis of knee, left knee
M70.61 Trochanteric bursitis, right hip
M70.62 Trochanteric bursitis, left hip
M70.71 Other bursitis of hip, right hip
M70.72 Other bursitis of hip, left hip
M71.111 Other infective bursitis, right shoulder
M71.112 Other infective bursitis, left shoulder
M71.121 Other infective bursitis, right elbow
M71.122 Other infective bursitis, left elbow
M71.131 Other infective bursitis, right wrist
M71.132 Other infective bursitis, left wrist
M71.141 Other infective bursitis, right hand
M71.142 Other infective bursitis, left hand
M71.151 Other infective bursitis, right hip
M71.152 Other infective bursitis, left hip
M71.161 Other infective bursitis, right knee
M71.162 Other infective bursitis, left knee
M71.171 Other infective bursitis, right ankle and foot
M71.172 Other infective bursitis, left ankle and foot
M71.18 Other infective bursitis, other site
M71.19 Other infective bursitis, multiple sites
M71.30 Other bursal cyst, unspecified site
M71.521 Other bursitis, not elsewhere classified, right elbow
M71.522 Other bursitis, not elsewhere classified, left elbow
M71.531 Other bursitis, not elsewhere classified, right wrist
M71.532 Other bursitis, not elsewhere classified, left wrist
M71.541 Other bursitis, not elsewhere classified, right hand
M71.542 Other bursitis, not elsewhere classified, left hand
M71.551 Other bursitis, not elsewhere classified, right hip
M71.552 Other bursitis, not elsewhere classified, left hip
M71.561 Other bursitis, not elsewhere classified, right knee
M71.562 Other bursitis, not elsewhere classified, left knee
M71.571 Other bursitis, not elsewhere classified, right ankle and foot
M71.572 Other bursitis, not elsewhere classified, left ankle and foot
M71.58* Other bursitis, not elsewhere classified, other site
M72.0 Palmar fascial fibromatosis [Dupuytren]
M72.2 Plantar fascial fibromatosis
M72.9 Fibroblastic disorder, unspecified
M75.01 Adhesive capsulitis of right shoulder
M75.02 Adhesive capsulitis of left shoulder
M75.101 Unspecified rotator cuff tear or rupture of right shoulder, not specified as traumatic
M75.102 Unspecified rotator cuff tear or rupture of left shoulder, not specified as traumatic
M75.21 Bicipital tendinitis, right shoulder
M75.22 Bicipital tendinitis, left shoulder
M75.30 Calcific tendinitis of unspecified shoulder
M75.31 Calcific tendinitis of right shoulder
M75.32 Calcific tendinitis of left shoulder
M75.41 Impingement syndrome of right shoulder
M75.42 Impingement syndrome of left shoulder
M75.51 Bursitis of right shoulder
M75.52 Bursitis of left shoulder
M75.81 Other shoulder lesions, right shoulder
M75.82 Other shoulder lesions, left shoulder
M75.91 Shoulder lesion, unspecified, right shoulder
M75.92 Shoulder lesion, unspecified, left shoulder
M76.01 Gluteal tendinitis, right hip
M76.02 Gluteal tendinitis, left hip
M76.11 Psoas tendinitis, right hip
M76.12 Psoas tendinitis, left hip
M76.21 Iliac crest spur, right hip
M76.22 Iliac crest spur, left hip
M76.31 Iliotibial band syndrome, right leg
M76.32 Iliotibial band syndrome, left leg
M76.41 Tibial collateral bursitis [Pellegrini-Stieda], right leg
M76.42 Tibial collateral bursitis [Pellegrini-Stieda], left leg
M76.51 Patellar tendinitis, right knee
M76.52 Patellar tendinitis, left knee
M76.61 Achilles tendinitis, right leg
M76.62 Achilles tendinitis, left leg
M76.71 Peroneal tendinitis, right leg
M76.72 Peroneal tendinitis, left leg
M76.811 Anterior tibial syndrome, right leg
M76.812 Anterior tibial syndrome, left leg
M76.821 Posterior tibial tendinitis, right leg
M76.822 Posterior tibial tendinitis, left leg
M76.891 Other specified enthesopathies of right lower limb, excluding foot
M76.892 Other specified enthesopathies of left lower limb, excluding foot
M76.899 Other specified enthesopathies of unspecified lower limb, excluding foot
M76.9 Unspecified enthesopathy, lower limb, excluding foot
M77.01 Medial epicondyritis, right elbow
M77.02 Medial epicondyritis, left elbow
M77.11 Lateral epicondyritis, right elbow
M77.12 Lateral epicondyritis, left elbow
M77.21 Periarthritis, right wrist
M77.22 Periarthritis, left wrist
M77.30 Calcaneal spur, unspecified foot
M77.31* Calcaneal spur, right foot
M77.32* Calcaneal spur, left foot
M77.41 Metatarsalgia, right foot
M77.42 Metatarsalgia, left foot
M77.51* Other enthesopathy of right foot
M77.52* Other enthesopathy of left foot
M77.8 Other enthesopathies, not elsewhere classified

**Group 2 Medical Necessity ICD-10 Codes Asterisk Explanation: **

**Use ICD-10-CM code M77.31-M77.32 for heel pain syndrome**

*Use ICD-10-CM code M77.51-M77.52 for calcaneal bursitis*

*Use ICD-10-CM code M71.58 for bursitis in the foot*

**Group 3 Paragraph: EPIDURAL AND INTRATHECAL INJECTIONS:**

**INTERLAMINAR AND CAUDAL (CPT codes 62310, 62311, 62318, 62319)**

**Group 3 Codes:**

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
</table>
B02.0  Zoster encephalitis
B02.23 Postherpetic polyneuropathy
B02.29 Other postherpetic nervous system involvement
G03.1  Chronic meningitis
G54.2  Cervical root disorders, not elsewhere classified
G54.3  Thoracic root disorders, not elsewhere classified
G54.4  Lumbosacral root disorders, not elsewhere classified
G54.6  Phantom limb syndrome with pain
G54.7  Phantom limb syndrome without pain
G56.40 Causalgia of unspecified upper limb
G56.41 Causalgia of right upper limb
G56.42 Causalgia of left upper limb
G57.70 Causalgia of unspecified lower limb
G57.71 Causalgia of right lower limb
G57.72 Causalgia of left lower limb
G89.11 Acute pain due to trauma
G89.12 Acute post-thoracotomy pain
G89.18 Other acute postprocedural pain
G89.21 Chronic pain due to trauma
G89.22 Chronic post-thoracotomy pain
G89.28 Other chronic postprocedural pain
G90.511 Complex regional pain syndrome I of right upper limb
G90.512 Complex regional pain syndrome I of left upper limb
G90.513 Complex regional pain syndrome I of upper limb, bilateral
G90.521 Complex regional pain syndrome I of right lower limb
G90.522 Complex regional pain syndrome I of left lower limb
G90.523 Complex regional pain syndrome I of lower limb, bilateral
G90.59 Complex regional pain syndrome I of other specified site
M43.01 Spondylolysis, occipito-atlanto-axial region
M43.02 Spondylolysis, cervical region
M43.03 Spondylolysis, cervicothoracic region
M43.04 Spondylolysis, thoracic region
M43.05 Spondylolysis, thoracolumbar region
M43.06 Spondylolysis, lumbar region
M43.07 Spondylolysis, lumbosacral region
M43.08 Spondylolysis, sacral and sacrococcygeal region
M43.09 Spondylolysis, multiple sites in spine
M43.11 Spondylolisthesis, occipito-atlanto-axial region
M43.12 Spondylolisthesis, cervical region
M43.13 Spondylolisthesis, cervicothoracic region
M43.14 Spondylolisthesis, thoracic region
M43.15  Spondylolisthesis, thoracolumbar region  
M43.16  Spondylolisthesis, lumbar region  
M43.17  Spondylolisthesis, lumbosacral region  
M43.18  Spondylolisthesis, sacral and sacrococcygeal region  
M43.19  Spondylolisthesis, multiple sites in spine  
M47.011  Anterior spinal artery compression syndromes, occipito-atlanto-axial region  
M47.012  Anterior spinal artery compression syndromes, cervical region  
M47.013  Anterior spinal artery compression syndromes, cervicothoracic region  
M47.014  Anterior spinal artery compression syndromes, thoracic region  
M47.015  Anterior spinal artery compression syndromes, thoracolumbar region  
M47.016  Anterior spinal artery compression syndromes, lumbar region  
M47.021  Vertebral artery compression syndromes, occipito-atlanto-axial region  
M47.022  Vertebral artery compression syndromes, cervical region  
M47.11  Other spondylosis with myelopathy, occipito-atlanto-axial region  
M47.12  Other spondylosis with myelopathy, cervical region  
M47.13  Other spondylosis with myelopathy, cervicothoracic region  
M47.14  Other spondylosis with myelopathy, thoracic region  
M47.15  Other spondylosis with myelopathy, thoracolumbar region  
M47.16  Other spondylosis with myelopathy, lumbar region  
M47.21  Other spondylosis with radiculopathy, occipito-atlanto-axial region  
M47.22  Other spondylosis with radiculopathy, cervical region  
M47.23  Other spondylosis with radiculopathy, cervicothoracic region  
M47.24  Other spondylosis with radiculopathy, thoracic region  
M47.25  Other spondylosis with radiculopathy, thoracolumbar region  
M47.26  Other spondylosis with radiculopathy, lumbar region  
M47.27  Other spondylosis with radiculopathy, lumbosacral region  
M47.28  Other spondylosis with radiculopathy, sacral and sacrococcygeal region  
M47.811  Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region  
M47.812  Spondylosis without myelopathy or radiculopathy, cervical region  
M47.813  Spondylosis without myelopathy or radiculopathy, cervicothoracic region  
M47.814  Spondylosis without myelopathy or radiculopathy, thoracic region  
M47.815  Spondylosis without myelopathy or radiculopathy, thoracolumbar region  
M47.816  Spondylosis without myelopathy or radiculopathy, lumbar region  
M47.817  Spondylosis without myelopathy or radiculopathy, lumbosacral region  
M47.818  Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region  
M47.891  Other spondylosis, occipito-atlanto-axial region  
M47.892  Other spondylosis, cervical region  
M47.893  Other spondylosis, cervicothoracic region  
M47.894  Other spondylosis, thoracic region  
M47.895  Other spondylosis, thoracolumbar region  
M47.896  Other spondylosis, lumbar region
M47.897 Other spondylosis, lumbosacral region
M47.898 Other spondylosis, sacral and sacrococcygeal region
M47.9 Spondylosis, unspecified
M48.01 Spinal stenosis, occipito-atlanto-axial region
M48.02 Spinal stenosis, cervical region
M48.03 Spinal stenosis, cervicothoracic region
M48.04 Spinal stenosis, thoracic region
M48.05 Spinal stenosis, thoracolumbar region
M48.06 Spinal stenosis, lumbar region
M48.07 Spinal stenosis, lumbosacral region
M48.50XA Collapsed vertebra, not elsewhere classified, site unspecified, initial encounter for fracture
M48.51XA Collapsed vertebra, not elsewhere classified, occipito-atlanto-axial region, initial encounter for fracture
M48.52XA Collapsed vertebra, not elsewhere classified, cervical region, initial encounter for fracture
M48.53XA Collapsed vertebra, not elsewhere classified, cervicothoracic region, initial encounter for fracture
M48.54XA Collapsed vertebra, not elsewhere classified, thoracic region, initial encounter for fracture
M48.55XA Collapsed vertebra, not elsewhere classified, thoracolumbar region, initial encounter for fracture
M48.56XA Collapsed vertebra, not elsewhere classified, lumbar region, initial encounter for fracture
M48.57XA Collapsed vertebra, not elsewhere classified, lumbosacral region, initial encounter for fracture
M48.58XA Collapsed vertebra, not elsewhere classified, sacral and sacrococcygeal region, initial encounter for fracture
M50.01 Cervical disc disorder with myelopathy, occipito-atlanto-axial region
M50.02 Cervical disc disorder with myelopathy, mid-cervical region
M50.03 Cervical disc disorder with myelopathy, cervicothoracic region
M50.11 Cervical disc disorder with radiculopathy, occipito-atlanto-axial region
M50.12 Cervical disc disorder with radiculopathy, mid-cervical region
M50.13 Cervical disc disorder with radiculopathy, cervicothoracic region
M50.21 Other cervical disc displacement, occipito-atlanto-axial region
M50.22 Other cervical disc displacement, mid-cervical region
M50.23 Other cervical disc displacement, cervicothoracic region
M50.31 Other cervical disc degeneration, occipito-atlanto-axial region
M50.32 Other cervical disc degeneration, mid-cervical region
M50.33 Other cervical disc degeneration, cervicothoracic region
M51.04 Intervertebral disc disorders with myelopathy, thoracic region
M51.05 Intervertebral disc disorders with myelopathy, thoracolumbar region
M51.06 Intervertebral disc disorders with myelopathy, lumbar region
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<td>Lumbago with sciatica, left side</td>
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<td>M84.68XA</td>
<td>Pathological fracture in other disease, other site, initial encounter for</td>
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<td>Subluxation stenosis of neural canal of lumbar region</td>
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<td>Osseous stenosis of neural canal of cervical region</td>
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<td>Osseous stenosis of neural canal of thoracic region</td>
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<td>M99.33</td>
<td>Osseous stenosis of neural canal of lumbar region</td>
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</table>
M99.40 Connective tissue stenosis of neural canal of head region
M99.41 Connective tissue stenosis of neural canal of cervical region
M99.42 Connective tissue stenosis of neural canal of thoracic region
M99.43 Connective tissue stenosis of neural canal of lumbar region
M99.50 Intervertebral disc stenosis of neural canal of head region
M99.51 Intervertebral disc stenosis of neural canal of cervical region
M99.52 Intervertebral disc stenosis of neural canal of thoracic region
M99.53 Intervertebral disc stenosis of neural canal of lumbar region
M99.60 Osseous and subluxation stenosis of intervertebral foramina of head region
M99.61 Osseous and subluxation stenosis of intervertebral foramina of cervical region
M99.62 Osseous and subluxation stenosis of intervertebral foramina of thoracic region
M99.63 Osseous and subluxation stenosis of intervertebral foramina of lumbar region
M99.70 Connective tissue and disc stenosis of intervertebral foramina of head region
M99.71 Connective tissue and disc stenosis of intervertebral foramina of cervical region
M99.72 Connective tissue and disc stenosis of intervertebral foramina of thoracic region
M99.73 Connective tissue and disc stenosis of intervertebral foramina of lumbar region
Q76.2 Congenital spondylolisthesis
R52* Pain, unspecified
S14.2XXA Injury of nerve root of cervical spine, initial encounter
S24.2XXA Injury of nerve root of thoracic spine, initial encounter
S34.21XA Injury of nerve root of lumbar spine, initial encounter
S34.22XA Injury of nerve root of sacral spine, initial encounter
Z01.89* Encounter for other specified special examinations
Z79.01* Long term (current) use of anticoagulants

**Use ICD-10-CM code Z01.89 only when procedure codes 62310, 62311, 62318, 62319 are used for injection of agents for diagnostic procedures unrelated to pain management (e.g., cisternography).

**Use Z79.01 only as a supplemental code in addition to primary diagnosis, when anticoagulant therapy has been discontinued to facilitate therapeutic injections for pain management.)

*Use ICD-10-CM code R52 for obstetric pain management.

Group 4 Paragraph: INTRATHECAL BACLOFEN ADMINISTRATION (62310, 62311, 62318, 62319, J0475, J0476)

Use ICD-10-CM codes M62.40-M62.838 (spasm of muscle) to report treatment of spasticity secondary to spastic hemiplegia and hemiparesis.

The following may include a component of spasticity which may be appropriate for baclofen administration (J0475 and J0476). Long-term administration is more appropriately accomplished...
via implanted infusion pumps.

**Group 4 Codes:**

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
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<tr>
<td>G04.1</td>
<td>Tropical spastic paraplegia</td>
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<td>G11.4</td>
<td>Hereditary spastic paraplegia</td>
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<td>G24.09</td>
<td>Other drug induced dystonia</td>
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<tr>
<td>G24.2</td>
<td>Idiopathic nonfamilial dystonia</td>
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<td>G24.8</td>
<td>Other dystonia</td>
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<td>G35</td>
<td>Multiple sclerosis</td>
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<td>G80.0</td>
<td>Spastic quadriplegic cerebral palsy</td>
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<td>G80.1</td>
<td>Spastic diplegic cerebral palsy</td>
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<td>Spastic hemiplegic cerebral palsy</td>
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<td>G80.4</td>
<td>Ataxic cerebral palsy</td>
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<td>G80.8</td>
<td>Other cerebral palsy</td>
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<td>Cerebral palsy, unspecified</td>
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<td>G81.11</td>
<td>Spastic hemiplegia affecting right dominant side</td>
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<td>G81.12</td>
<td>Spastic hemiplegia affecting left dominant side</td>
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<tr>
<td>G81.13</td>
<td>Spastic hemiplegia affecting right nondominant side</td>
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<td>Paraplegia, unspecified</td>
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<td>Paraplegia, complete</td>
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<td>Paraplegia, incomplete</td>
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<td>Quadriplegia, unspecified</td>
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<td>Quadriplegia, C1-C4 complete</td>
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<td>G82.52</td>
<td>Quadriplegia, C1-C4 incomplete</td>
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<td>G82.53</td>
<td>Quadriplegia, C5-C7 complete</td>
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<td>G82.54</td>
<td>Quadriplegia, C5-C7 incomplete</td>
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<td>Diplegia of upper limbs</td>
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<td>Monoplegia of lower limb affecting right dominant side</td>
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<td>G83.12</td>
<td>Monoplegia of lower limb affecting left dominant side</td>
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<td>G83.21</td>
<td>Monoplegia of upper limb affecting right dominant side</td>
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<td>G83.22</td>
<td>Monoplegia of upper limb affecting left dominant side</td>
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<td>G83.23</td>
<td>Monoplegia of upper limb affecting right nondominant side</td>
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<td>G83.24</td>
<td>Monoplegia of upper limb affecting left nondominant side</td>
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<td>G83.4</td>
<td>Cauda equina syndrome</td>
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G83.5 Locked-in state
G83.81 Brown-Sequard syndrome
G83.82 Anterior cord syndrome
G83.83 Posterior cord syndrome
G83.84 Todd's paralysis (postepileptic)
G83.89 Other specified paralytic syndromes
G95.11 Acute infarction of spinal cord (embolic) (nonembolic)
G95.19 Other vascular myelopathies
M62.40 Contracture of muscle, unspecified site
M62.411 Contracture of muscle, right shoulder
M62.412 Contracture of muscle, left shoulder
M62.421 Contracture of muscle, right upper arm
M62.422 Contracture of muscle, left upper arm
M62.431 Contracture of muscle, right forearm
M62.432 Contracture of muscle, left forearm
M62.441 Contracture of muscle, right hand
M62.442 Contracture of muscle, left hand
M62.451 Contracture of muscle, right thigh
M62.452 Contracture of muscle, left thigh
M62.461 Contracture of muscle, right lower leg
M62.462 Contracture of muscle, left lower leg
M62.471 Contracture of muscle, right ankle and foot
M62.472 Contracture of muscle, left ankle and foot
M62.48 Contracture of muscle, other site
M62.49 Contracture of muscle, multiple sites
M62.831 Muscle spasm of calf
M62.838 Other muscle spasm

Group 5 Paragraph: EPIDURAL INJECTIONS – TRANSFORAMINAL (64479, 64480, 64483, 64484)

Group 5 Codes:

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<td>Postherpetic polyneuropathy</td>
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<td>B02.29</td>
<td>Other postherpetic nervous system involvement</td>
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<td>G54.2</td>
<td>Cervical root disorders, not elsewhere classified</td>
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<tr>
<td>G54.3</td>
<td>Thoracic root disorders, not elsewhere classified</td>
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</table>
G54.4  Lumbosacral root disorders, not elsewhere classified
G89.21 Chronic pain due to trauma
G89.22 Chronic post-thoracotomy pain
G89.28 Other chronic postprocedural pain
G89.3  Neoplasm related pain (acute) (chronic)
M47.011 Anterior spinal artery compression syndromes, occipito-atlanto-axial region
M47.012 Anterior spinal artery compression syndromes, cervical region
M47.013 Anterior spinal artery compression syndromes, cervicothoracic region
M47.014 Anterior spinal artery compression syndromes, thoracic region
M47.015 Anterior spinal artery compression syndromes, thoracolumbar region
M47.016 Anterior spinal artery compression syndromes, lumbar region
M47.021 Vertebral artery compression syndromes, occipito-atlanto-axial region
M47.022 Vertebral artery compression syndromes, cervical region
M47.10  Other spondylosis with myelopathy, site unspecified
M47.11 Other spondylosis with myelopathy, occipito-atlanto-axial region
M47.12 Other spondylosis with myelopathy, cervical region
M47.13 Other spondylosis with myelopathy, cervicothoracic region
M47.14 Other spondylosis with myelopathy, thoracic region
M47.15 Other spondylosis with myelopathy, thoracolumbar region
M47.16 Other spondylosis with myelopathy, lumbar region
M47.20 Other spondylosis with radiculopathy, site unspecified
M47.21 Other spondylosis with radiculopathy, occipito-atlanto-axial region
M47.22 Other spondylosis with radiculopathy, cervical region
M47.23 Other spondylosis with radiculopathy, cervicothoracic region
M47.24 Other spondylosis with radiculopathy, thoracic region
M47.25 Other spondylosis with radiculopathy, thoracolumbar region
M47.26 Other spondylosis with radiculopathy, lumbar region
M47.27 Other spondylosis with radiculopathy, lumbosacral region
M47.28 Other spondylosis with radiculopathy, sacral and sacrococcygeal region
M47.811 Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region
M47.812 Spondylosis without myelopathy or radiculopathy, cervical region
M47.813 Spondylosis without myelopathy or radiculopathy, cervicothoracic region
M47.814 Spondylosis without myelopathy or radiculopathy, thoracic region
M47.815 Spondylosis without myelopathy or radiculopathy, thoracolumbar region
M47.816 Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817 Spondylosis without myelopathy or radiculopathy, lumbosacral region
M47.818 Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region
M47.819 Spondylosis without myelopathy or radiculopathy, site unspecified
M47.891 Other spondylosis, occipito-atlanto-axial region
M47.892 Other spondylosis, cervical region
M47.893 Other spondylosis, cervicothoracic region
M47.894 Other spondylosis, thoracic region
M47.895 Other spondylosis, thoracolumbar region
M47.896 Other spondylosis, lumbar region
M47.897 Other spondylosis, lumbosacral region
M47.898 Other spondylosis, sacral and sacrococcygeal region
M47.899 Other spondylosis, site unspecified
M47.9 Spondylosis, unspecified
M48.01 Spinal stenosis, occipito-atlanto-axial region
M48.02 Spinal stenosis, cervical region
M48.03 Spinal stenosis, cervicothoracic region
M48.04 Spinal stenosis, thoracic region
M48.05 Spinal stenosis, thoracolumbar region
M48.06 Spinal stenosis, lumbar region
M48.07 Spinal stenosis, lumbosacral region
M48.50XA Collapsed vertebra, not elsewhere classified, site unspecified, initial encounter for fracture
M48.51XA Collapsed vertebra, not elsewhere classified, occipito-atlanto-axial region, initial encounter for fracture
M48.52XA Collapsed vertebra, not elsewhere classified, cervical region, initial encounter for fracture
M48.53XA Collapsed vertebra, not elsewhere classified, cervicothoracic region, initial encounter for fracture
M48.54XA Collapsed vertebra, not elsewhere classified, thoracic region, initial encounter for fracture
M48.55XA Collapsed vertebra, not elsewhere classified, thoracolumbar region, initial encounter for fracture
M48.56XA Collapsed vertebra, not elsewhere classified, lumbar region, initial encounter for fracture
M48.57XA Collapsed vertebra, not elsewhere classified, lumbosacral region, initial encounter for fracture
M48.58XA Collapsed vertebra, not elsewhere classified, sacral and sacrococcygeal region, initial encounter for fracture
M50.01 Cervical disc disorder with myelopathy, occipito-atlanto-axial region
M50.02 Cervical disc disorder with myelopathy, mid-cervical region
M50.03 Cervical disc disorder with myelopathy, cervicothoracic region
M50.11 Cervical disc disorder with radiculopathy, occipito-atlanto-axial region
M50.12 Cervical disc disorder with radiculopathy, mid-cervical region
M50.13 Cervical disc disorder with radiculopathy, cervicothoracic region
M50.21 Other cervical disc displacement, occipito-atlanto-axial region
M50.22 Other cervical disc displacement, mid-cervical region
M50.23 Other cervical disc displacement, cervicothoracic region
M50.31 Other cervical disc degeneration, occipito-atlanto-axial region
M50.32 Other cervical disc degeneration, mid-cervical region
M50.33 Other cervical disc degeneration, cervicothoracic region
M51.04 Intervertebral disc disorders with myelopathy, thoracic region
M51.05 Intervertebral disc disorders with myelopathy, thoracolumbar region
M51.06 Intervertebral disc disorders with myelopathy, lumbar region
M51.14 Intervertebral disc disorders with radiculopathy, thoracic 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
M51.24 Other intervertebral disc displacement, thoracic region
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M51.26 Other intervertebral disc displacement, lumbar region
M51.27 Other intervertebral disc displacement, lumbosacral region
M51.34 Other intervertebral disc degeneration, thoracic region
M51.35 Other intervertebral disc degeneration, thoracolumbar region
M51.36 Other intervertebral disc degeneration, lumbar region
M51.37 Other intervertebral disc degeneration, lumbosacral region
M51.9 Unspecified thoracic, thoracolumbar and lumbosacral intervertebral disc disorder
M54.11 Radiculopathy, occipito-atlanto-axial region
M54.12 Radiculopathy, cervical region
M54.13 Radiculopathy, cervicothoracic region
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
M54.16 Radiculopathy, lumbar region
M54.17 Radiculopathy, lumbosacral region
M54.31 Sciatica, right side
M54.32 Sciatica, left side
M54.41 Lumbago with sciatica, right side
M54.42 Lumbago with sciatica, left side
M80.08XA Age-related osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture
M80.88XA Other osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture
M84.58XA Pathological fracture in neoplastic disease, vertebrae, initial encounter for fracture
M84.68XA Pathological fracture in other disease, other site, initial encounter for fracture
M96.1 Postlaminectomy syndrome, not elsewhere classified
M99.20 Subluxation stenosis of neural canal of head region
M99.21 Subluxation stenosis of neural canal of cervical region
M99.22 Subluxation stenosis of neural canal of thoracic region
M99.23 Subluxation stenosis of neural canal of lumbar region
M99.30 Osseous stenosis of neural canal of head region
M99.31 Osseous stenosis of neural canal of cervical region
M99.32 Osseous stenosis of neural canal of thoracic region
M99.33  Osseous stenosis of neural canal of lumbar region
M99.40  Connective tissue stenosis of neural canal of head region
M99.41  Connective tissue stenosis of neural canal of cervical region
M99.42  Connective tissue stenosis of neural canal of thoracic region
M99.43  Connective tissue stenosis of neural canal of lumbar region
M99.50  Intervertebral disc stenosis of neural canal of head region
M99.51  Intervertebral disc stenosis of neural canal of cervical region
M99.52  Intervertebral disc stenosis of neural canal of thoracic region
M99.53  Intervertebral disc stenosis of neural canal of lumbar region
M99.60  Osseous and subluxation stenosis of intervertebral foramina of head region
M99.61  Osseous and subluxation stenosis of intervertebral foramina of cervical region
M99.62  Osseous and subluxation stenosis of intervertebral foramina of thoracic region
M99.63  Osseous and subluxation stenosis of intervertebral foramina of lumbar region
M99.70  Connective tissue and disc stenosis of intervertebral foramina of head region
M99.71  Connective tissue and disc stenosis of intervertebral foramina of cervical region
M99.72  Connective tissue and disc stenosis of intervertebral foramina of thoracic region
M99.73  Connective tissue and disc stenosis of intervertebral foramina of lumbar region
S14.2XXA Injury of nerve root of cervical spine, initial encounter
S24.2XXA Injury of nerve root of thoracic spine, initial encounter
S34.21XA Injury of nerve root of lumbar spine, initial encounter
S34.22XA Injury of nerve root of sacral spine, initial encounter

**Group 6 Paragraph: PARAVERTERBAL JOINT/NERVE BLOCKS – DIAGNOSTIC AND THERAPEUTIC (CPT codes 64490, 64491, 64492, 64493, 64494, 64495) and PARAVERTERBAL JOINT/NERVE DENERVATION (CPT codes 64633, 64634, 64635, 64636, 64999)**

**Group 6 Codes:**

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M12.9*</td>
<td>Arthropathy, unspecified</td>
</tr>
<tr>
<td>M47.011</td>
<td>Anterior spinal artery compression syndromes, occipito-atlanto-axial region</td>
</tr>
<tr>
<td>M47.012</td>
<td>Anterior spinal artery compression syndromes, cervical region</td>
</tr>
<tr>
<td>M47.013</td>
<td>Anterior spinal artery compression syndromes, cervicothoracic region</td>
</tr>
<tr>
<td>M47.014</td>
<td>Anterior spinal artery compression syndromes, thoracic region</td>
</tr>
<tr>
<td>M47.015</td>
<td>Anterior spinal artery compression syndromes, thoracolumbar region</td>
</tr>
<tr>
<td>M47.016</td>
<td>Anterior spinal artery compression syndromes, lumbar region</td>
</tr>
<tr>
<td>M47.021</td>
<td>Vertebral artery compression syndromes, occipito-atlanto-axial region</td>
</tr>
<tr>
<td>M47.022</td>
<td>Vertebral artery compression syndromes, cervical region</td>
</tr>
<tr>
<td>M47.11</td>
<td>Other spondylosis with myelopathy, occipito-atlanto-axial region</td>
</tr>
</tbody>
</table>
M47.12 Other spondylosis with myelopathy, cervical region
M47.13 Other spondylosis with myelopathy, cervicothoracic region
M47.14 Other spondylosis with myelopathy, thoracic region
M47.15 Other spondylosis with myelopathy, thoracolumbar region
M47.16 Other spondylosis with myelopathy, lumbar region
M47.21 Other spondylosis with radiculopathy, occipito-atlanto-axial region
M47.22 Other spondylosis with radiculopathy, cervical region
M47.23 Other spondylosis with radiculopathy, cervicothoracic region
M47.24 Other spondylosis with radiculopathy, thoracic region
M47.25 Other spondylosis with radiculopathy, thoracolumbar region
M47.26 Other spondylosis with radiculopathy, lumbar region
M47.27 Other spondylosis with radiculopathy, lumbosacral region
M47.28 Other spondylosis with radiculopathy, sacral and sacroccocygeal region
M47.811 Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region
M47.812 Spondylosis without myelopathy or radiculopathy, cervical region
M47.813 Spondylosis without myelopathy or radiculopathy, cervicothoracic region
M47.814 Spondylosis without myelopathy or radiculopathy, thoracic region
M47.815 Spondylosis without myelopathy or radiculopathy, thoracolumbar region
M47.816 Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817 Spondylosis without myelopathy or radiculopathy, lumbosacral region
M47.818 Spondylosis without myelopathy or radiculopathy, sacral and sacroccocygeal region
M47.891 Other spondylosis, occipito-atlanto-axial region
M47.892 Other spondylosis, cervical region
M47.893 Other spondylosis, cervicothoracic region
M47.894 Other spondylosis, thoracic region
M47.895 Other spondylosis, thoracolumbar region
M47.896 Other spondylosis, lumbar region
M47.897 Other spondylosis, lumbosacral region
M47.898 Other spondylosis, sacral and sacroccocygeal region

M80.00XK - M84.68XK* - Opens in a new window
Age-related osteoporosis with current pathological fracture, unspecified site, subsequent encounter for fracture with nonunion - Pathological fracture in other disease, other site, subsequent encounter for fracture with nonunion

S02.0XXK - S02.402K* - Opens in a new window
Fracture of vault of skull, subsequent encounter for fracture with nonunion - Zygomatic fracture, unspecified, subsequent encounter for fracture with nonunion

S02.411K - S12.691K* - Opens in a new window
LeFort I fracture, subsequent encounter for fracture with nonunion - Other nondisplaced fracture of seventh cervical vertebra, subsequent encounter for fracture with nonunion

S13.4XXA* Sprain of ligaments of cervical spine, initial encounter
S13.8XXA* Sprain of joints and ligaments of other parts of neck, initial encounter
S16.1XXA* Strain of muscle, fascia and tendon at neck level, initial encounter
S22.000K - S22.022K* - Opens in a new window
Wedge compression fracture of unspecified thoracic vertebra, subsequent encounter for fracture with nonunion - Unstable burst fracture of second thoracic vertebra, subsequent encounter for fracture with nonunion
S22.028K - S22.9XXK* - Opens in a new window
Other fracture of second thoracic vertebra, subsequent encounter for fracture with nonunion - Fracture of bony thorax, part unspecified, subsequent encounter for fracture with nonunion
S23.3XXA Sprain of ligaments of thoracic spine, initial encounter
S23.8XXA Sprain of other specified parts of thorax, initial encounter
S32.000K - S32.9XXK* - Opens in a new window
Wedge compression fracture of unspecified lumbar vertebra, subsequent encounter for fracture with nonunion - Fracture of unspecified parts of lumbosacral spine and pelvis, subsequent encounter for fracture with nonunion
S33.5XXA Sprain of ligaments of lumbar spine, initial encounter
S42.001K - S49.039K* - Opens in a new window
Fracture of unspecified part of right clavicle, subsequent encounter for fracture with nonunion - Salter Harris Type III physeal fracture of upper end of humerus, unspecified arm, subsequent encounter for fracture with nonunion
S49.041K - S52.101K* - Opens in a new window
Salter-Harris Type IV physeal fracture of upper end of humerus, right arm, subsequent encounter for fracture with nonunion - Unspecified fracture of upper end of right radius, subsequent encounter for closed fracture with nonunion
S52.101M - S52.235M* - Opens in a new window
Unspecified fracture of upper end of right radius, subsequent encounter for open fracture type I or II with nonunion - Nondisplaced oblique fracture of shaft of left ulna, subsequent encounter for open fracture type I or II with nonunion
S52.235N - S52.321N* - Opens in a new window
Nondisplaced oblique fracture of shaft of left ulna, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion - Displaced transverse fracture of shaft of right radius, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion
S52.322K - S52.382K* - Opens in a new window
Displaced transverse fracture of shaft of left radius, subsequent encounter for closed fracture with nonunion - Bent bone of left radius, subsequent encounter for closed fracture with nonunion
S52.382M - S52.601M* - Opens in a new window
Bent bone of left radius, subsequent encounter for open fracture type I or II with nonunion - Unspecified fracture of lower end of right ulna, subsequent encounter for open fracture type I or II with nonunion
S52.601N - S59.299K* - Opens in a new window
Unspecified fracture of lower end of right ulna, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion - Other physeal fracture of lower end of radius, unspecified arm, subsequent encounter for fracture with nonunion
S62.001K - S62.254K* - Opens in a new window
Unspecified fracture of navicular [scaphoid] bone of right wrist, subsequent encounter for fracture with nonunion - Nondisplaced fracture of neck of first metacarpal bone, right hand, subsequent encounter for fracture with nonunion
Nondisplaced fracture of neck of first metacarpal bone, left hand, subsequent encounter for fracture with nonunion - Nondisplaced fracture of distal phalanx of unspecified thumb, subsequent encounter for fracture with nonunion

Fracture of unspecified phalanx of right index finger, subsequent encounter for fracture with nonunion - Displaced fracture of epiphysis (separation) (upper) of unspecified femur, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion

Nondisplaced fracture of epiphysis (separation) (upper) of right femur, subsequent encounter for closed fracture with nonunion - Nondisplaced fracture of greater trochanter of right femur, subsequent encounter for closed fracture with nonunion

Nondisplaced fracture of greater trochanter of right femur, subsequent encounter for open fracture type I or II with nonunion - Nondisplaced transverse fracture of shaft of right femur, subsequent encounter for open fracture type I or II with nonunion

Nondisplaced transverse fracture of shaft of right femur, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion - Displaced unspecified condyle fracture of lower end of right femur, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion

Displaced unspecified condyle fracture of lower end of left femur, subsequent encounter for closed fracture with nonunion - Nondisplaced supracondylar fracture with intracondylar extension of lower end of left femur, subsequent encounter for closed fracture with nonunion

Nondisplaced supracondylar fracture with intracondylar extension of lower end of left femur, subsequent encounter for open fracture type I or II with nonunion - Nondisplaced longitudinal fracture of right patella, subsequent encounter for open fracture type I or II with nonunion

Nondisplaced longitudinal fracture of right patella, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion - Displaced fracture of medial condyle of right tibia, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion

Displaced fracture of medial condyle of left tibia, subsequent encounter for closed fracture with nonunion - Nondisplaced oblique fracture of shaft of right tibia, subsequent encounter for closed fracture with nonunion

Nondisplaced oblique fracture of shaft of right tibia, subsequent encounter for open fracture type I or II with nonunion - Unspecified fracture of shaft of unspecified fibula, subsequent encounter for open fracture type I or II with nonunion

Unspecified fracture of shaft of unspecified fibula, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion - Other fracture of shaft of unspecified fibula, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion
Displaced fracture of medial malleolus of right tibia, subsequent encounter for closed fracture with nonunion - Nondisplaced Maisonneuve's fracture of left leg, subsequent encounter for closed fracture with nonunion

Nondisplaced Maisonneuve's fracture of left leg, subsequent encounter for open fracture type I or II with nonunion - Other physeal fracture of lower end of left fibula, subsequent encounter for fracture with nonunion

Other physeal fracture of lower end of unspecified fibula, subsequent encounter for fracture with nonunion - Displaced fracture of medial cuneiform of unspecified foot, subsequent encounter for fracture with nonunion

Nondisplaced fracture of medial cuneiform of right foot, subsequent encounter for fracture with nonunion - Unspecified fracture of unspecified toe(s), subsequent encounter for fracture with nonunion

Long term (current) use of anticoagulants

** Use ICD-10-CM code M12.9 for facet arthropathy.
* Use ICD-10-CM codes M80.00XK through S12.691K, S22.00K through S22.9XXK, S32.00K through S32.9XXK and S42.001K through SS92.919K for patients with pseudoarthrosis.
* Use ICD-10-CM codes S13.4XXA, S13.8XXA or S16.1XXA for whiplash and associated cervicogenic headache.
** Use Z79.01 only as a supplemental code in addition to primary diagnosis, when anticoagulant therapy has been discontinued to facilitate therapeutic injections for pain management.

** Group 7 Paragraph: SACROILIAC (SI) JOINT INJECTIONS (CPT codes 27096, G0260)

** Group 7 Codes:

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M12.9</td>
<td>Arthropathy, unspecified</td>
</tr>
<tr>
<td>M43.27</td>
<td>Fusion of spine, lumbosacral region</td>
</tr>
<tr>
<td>M43.28</td>
<td>Fusion of spine, sacral and sacrococcygeal region</td>
</tr>
<tr>
<td>M46.1</td>
<td>Sacroilitis, not elsewhere classified</td>
</tr>
<tr>
<td>M53.2X7</td>
<td>Spinal instabilities, lumbosacral region</td>
</tr>
<tr>
<td>M53.2X8</td>
<td>Spinal instabilities, sacral and sacrococcygeal region</td>
</tr>
<tr>
<td>M53.3</td>
<td>Sacrococcygeal disorders, not elsewhere classified</td>
</tr>
<tr>
<td>M53.86</td>
<td>Other specified dorsopathies, lumbar region</td>
</tr>
<tr>
<td>M53.87</td>
<td>Other specified dorsopathies, lumbosacral region</td>
</tr>
<tr>
<td>M53.88</td>
<td>Other specified dorsopathies, sacral and sacrococcygeal region</td>
</tr>
<tr>
<td>Z79.01*</td>
<td>Long term (current) use of anticoagulants</td>
</tr>
</tbody>
</table>
Group 7 Medical Necessity ICD-10 Codes Asterisk Explanation: ** Use Z79.01 only as a supplemental code in addition to primary diagnosis, when anticoagulant therapy has been discontinued to facilitate therapeutic injections for pain management.

ICD-10 Codes that DO NOT Support Medical Necessity

Additional ICD-10 Information

N/A

General Information

Associated Information

Documentation Requirements:

The patient's medical record must contain documentation that fully supports the medical necessity for services included within this LCD. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. Documentation must be available to Medicare upon request.

For the treatment of established trigger point, the patient’s medical record must clearly document:

- The evaluation leading to the diagnosis of the trigger point in an individual muscle, as detailed in the “Indications and Limitations of Coverage and/or Medical Necessity” section of this LCD;
- Identification of the affected muscle(s);
- Reason for selecting the trigger point injection as a therapeutic option, and whether it is being used as an initial or subsequent treatment for myofascial pain.

For injections of tendon sheaths, ligaments, ganglion cysts, carpal and tarsal tunnels, the medical record must include a procedural note documenting the reason for the injection at any particular site. If multiple sites are injected, documentation to substantiate that all the injections are reasonable and necessary must be present.

For interlaminar or caudal epidural and/or intrathecal injections including those treating
spasticity, transforaminal epidural injections, paravertebral joint/nerve injections and denervation, and sacroiliac joint injections the following lists general requirements:

- Complete initial evaluation including history and physical examination;
- Physiological and functional assessment, as necessary and feasible;
- Description of indications and medical necessity, as follows:
  - Suspected organic problem;
  - Pain and disability of moderate-to-severe degree;
  - No evidence of contraindications, such as severe spinal stenosis resulting in intraspinal obstruction, infection or predominantly psychogenic pain;
  - Nonresponsiveness to conservative modalities of treatment;
  - Responsiveness to prior interventions with improvement in physical and functional status for repeat blocks or other interventions
  - Repeating interventions only upon return of pain and deterioration in functional status.
- Assessment of this procedure outcome depends on the patient’s responses; therefore documentation should include:
  - Whether the injection/block was a diagnostic or therapeutic injection
  - Pre-and post-procedure evaluation of patient
  - Subjective and objective responses from the patient regarding pain, including assessment of the patient's pain level and ability to perform previously painful maneuvers after receiving an injection at time intervals appropriate to the duration of action of the substance injected.
- Significant pain relief is defined as greater than or equal to (\(>\geq\)) 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 \(>\geq\) 50% relief with the continued ability to perform previously painful maneuvers.
- The standard of care for all transforaminal epidural for chronic pain, paravertebral joint/nerve injections and denervations and sacroiliac (SI) joint injections requires that these procedures be performed under fluoroscopic- or CT-guided imaging. An image (plain radiograph with conventional film or specialized paper) or digital image documenting the needle position must be obtained whenever a substance is injected. A hard or digital copy of the needle placement should be retained to document accurate intra-articular placement. The medically necessary reason for the use of CT rather than fluoroscopy must be recorded.
- Claims billed for denervation procedures performed more frequently than once every six months at the same target level must be supported by documentation describing the unusual clinical circumstances and response to prior therapy(ies).

For epidural injections the following lists specific requirements:

- Nonresponsiveness to conservative modalities of treatment except in acute situations such as acute disc herniation with disabling and debilitating pain, herpes zoster and postherpetic neuralgia, reflex sympathetic dystrophy, and intractable pain secondary to carcinoma; and/or
• The patient is a candidate for surgery, but surgery is unacceptable to the patient or the patient is a poor surgical risk; and/or
• The epidural injection is being performed as a therapeutic adjunct to a conservative therapy program, to provide temporary relief and in order to facilitate a more aggressive rehabilitative program; and/or
• Repeated interventions are only acceptable with the return of pain and deterioration in functional status.
• Baclofen injections should document significant spasticity, not relieved by oral medications or other modalities.

For **paravertebral joint/nerve blocks – diagnostic and therapeutic** the following lists specific requirements:

Medical documentation in the patient’s medical record should substantiate the suspected diagnosis. As an example, "The patient had back pain without a strong radicular component, no associated neurologic deficit, and the pain was aggravated by hyperextension of the spine."

Document the total amount of injectate for all medications used, not to exceed 0.5 to 1 mL per facet joint or medial branch nerve. For therapeutic injections, the volume may be larger but should not exceed 2 mL.

The routine performance of facet joint/medial branch block(s) (both diagnostic and therapeutic) to both anatomic regions (cervicothoracic and lumbosacral) regions may prompt medical review. It is expected that the vast majority of patients will have positive responses in only one anatomic region.

For **paravertebral facet joint/nerve denervation** the following lists specific requirements:

Medical documentation should also demonstrate that the patient’s pain has been refractory to repeated attempts at medical management prior to paravertebral facet joint/nerve injections. In addition, the medical records must document a positive response to the paravertebral joint/nerve block injection for the joint being denervated. A positive response is defined as initial significant pain relief of \( \geq 80\%-90\% \) with the ability to perform previously painful maneuvers as defined above.

For **SI joint injections**, the following lists specific requirements:

Document the total amount of injectate for all medications used. No more than 2 - 3 ml of injectate should be injected to avoid bursting the synovial lining of the joint and having injectate disperse beyond the confines of the target joint.

**Appendices:**

Not applicable

**Utilization Guidelines:**
Trigger Point Injections:
Repeat **trigger point injections** may be necessary when there is evidence of persistent pain. Generally more than three injections of the same trigger point are not indicated. Evidence of partial improvements to the range of motion in any muscle area after an injection, but with persistent significant pain, would justify a repeat injection. The medical record must clearly reflect the medical necessity for repeated injections.

Injection Tendon Sheath, Ligament, Ganglion Cyst, Carpal and Tarsal Tunnel:

Most conditions that require injections into the tendon sheaths, ligaments or ganglion cysts should be resolved with one to three injections.

Interlaminar or Caudal Epidural and/or Intrathecal Injections (including those treating spasticity), Transforaminal Epidural Injections, Paravertebral Joint/Nerve Injections and Denervation, and Sacroiliac Joint Injections:

It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. Services performed in excess of established parameters may be subject to review for medical necessity. In addition to the information in “Indications and Limitations of Coverage and/or Medical Necessity,” the following additional guidelines are presented.

Frequency and Number of Injections or Interventions:

- In the diagnostic phase, a patient may receive epidural/intrathecal injections at intervals of no sooner than one week or preferably, two weeks. Blockade in cancer pain or when a continuous administration of local anesthetic is employed for reflex sympathetic dystrophy are exceptions.
- The number of injections in the diagnostic phase should be limited to no more than two times.
- Usually, no more than two, and occasionally three, diagnostic injections would be expected per date of service, per region (cervical/thoracic, lumbosacral).
- Once a structure is proven to be negative, no repeat interventions should be directed at that structure unless there is a new clinical presentation with symptoms, signs, and diagnostic studies of known reliability and validity that implicate the structure.
- The effect of injected corticosteroids may remain for several weeks. The benefit is attributed to a decrease of local inflammation and perhaps some local anesthetic effect. It is usually not necessary to repeat an injection if there has been a satisfactory response to the first injection. Patients who relapse after a satisfactory response may be candidates for another trial after an appropriate interval. Consideration should be given to the cumulative dose injected and limitations made to avoid steroid complications.
- In the therapeutic phase (after the diagnostic phase is completed), the frequency of interventional techniques should be two months or longer between each injection, provided that there is initial pain relief with diagnostic injections of greater than or equal to (\(\geq\))80%-90% with the ability to perform previously painful maneuvers, and a
persistent pain relief of \( \geq 50\% \) with the continued ability to perform previously painful maneuvers is maintained for at least six weeks. The therapeutic frequency must remain at least two months or longer for each region.

- In the treatment or therapeutic phase, the interventional procedures should be repeated only as medically necessary. No more than four therapeutic injections of any type (interlaminar or caudal epidural, transforaminal epidural, paravertebral facet joint or nerve, and/or sacroiliac joint) per region per patient per year are anticipated for the majority of patients.
  - Under unusual circumstances with a recurrent injury, carcinoma, or reflex sympathetic dystrophy, blocks may be repeated more frequently in the treatment phase after diagnosis/stabilization.
- Blind interlaminar or caudal epidurals are repeated only following appropriate response of at least four weeks. Failure to obtain appropriate response may indicate improper delivery of the drug and/or presence of a pain generator, which is non-responsive to epidural injection. Thus, subsequent epidural injections after a failed or inadequate response, if performed, should be under fluoroscopic visualization.
- Only paravertebral facet joint/nerves for which there has been a positive response should be injected for therapeutic reasons. No more than two, and occasionally three unilateral or bilateral joint/nerve injections per region would be anticipated per date of service.
- Only paravertebral facet joints for which there has been a positive response to at least two double-comparative local anesthetic injections should be denervated.
- Claims billed for denervation procedures performed more frequently than once every six months at the same target level must be supported by documentation describing the unusual clinical circumstances and response to prior therapy(ies).
- Only sacroiliac joints for which there has been a positive response should be injected for therapeutic reasons.

Sources of Information and Basis for Decision
This bibliography presents those sources that were obtained during the development of this policy. National Government Services is not responsible for the continuing viability of Web site addresses listed below.


American Medical Association (2004). *CPT Assistant.* Chicago IL.


Carrier Medical Directors Chronic Pain Management Clinical Workgroup, model policies on paravertebral nerve blocks, paravertebral facet joint nerve blocks and paravertebral facet joint denervation, 1997.


NGS and other Medicare contractors’ Local Coverage Determinations


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**Revision History Information**

N/A
Associated Documents

Attachments
N/A
Related Local Coverage Documents
Article(s)
  A52863 - Pain Management – Supplemental Instructions Article
Related National Coverage Documents
N/A
Public Version(s)
Updated on 04/02/2014 with effective dates 10/01/2014 - N/A

Local Coverage Article:
Pain Management – Supplemental Instructions Article (A52863)

Contractor Information

  Contractor Information Table

  Contractor Name
  National Government Services, Inc.

  

Article Information

General Information

  General Article Information Table

  Article ID
  A52863

  Original ICD-9 Article ID
  A48042
The information in this Supplemental Instructions Article (SIA) contains coding or other guidelines that complement the Local Coverage Determination (LCD) for Pain Management. The LCD can be accessed through our contractor Web site at www.NGSMedicare.com. It can also be found on the Medicare Coverage Database at www.cms.gov/medicare-coverage-database.

**Coding Information:**

Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS packaging edits. Refer to NCCI and OPPS requirements prior to billing Medicare.

For services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be reported on the claim.

A claim submitted without a valid ICD-10-CM diagnosis code will be returned to the provider as an incomplete claim under Section 1833(e) of the Social Security Act.
The diagnosis code(s) must best describe the patient's condition for which the service was performed.

All procedures related to pain management procedures performed by the physician/provider performed on the same day must be billed on the same claim.

Advance Beneficiary Notice of Noncoverage (ABN) Modifier Guidelines:

An ABN may be used for services which are likely to be non-covered, whether for medical necessity or for other reasons. Refer to CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 30, for complete instructions.

Specific coding guidelines for this policy:

For Paravertebral Spinal Nerves and Branches – Image guidance [fluoroscopy or CT] and any injection of contrast are inclusive components of 27096, 64479-64484, 64490-64495, and 64633-64636. Do not report CPT codes 27096, 64479-64484, 64490-64495, and 64633-64636 unless fluoroscopic- or CT-guidance is performed.

CPT code 72275 (Epidurography, radiological supervision and interpretation) represents a formal recorded and reported contrast study that includes fluoroscopy. Epidurography should only be reported when it is reasonable and medically necessary to perform a diagnostic study. It should not be billed for the usual work of fluoroscopy and dye injection that is integral to the injection(s) addressed in the policy and the supplemental instructions article.

Use CPT code 64999 (Unlisted procedure, nervous system) for pulsed radiofrequency and the denervation procedures of the sacro-iliac joint/nerves. Pulsed radiofrequency for denervation is considered investigational and therefore, not medically necessary. Sacro-iliac joint/nerve denervation procedures are also considered investigational and not medically necessary.

Unless otherwise specified in the long description, HCPCS descriptions refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPCS code does not exist for the compounded product, the provider should report an appropriate unlisted code such as J3490.

Acupuncture, a non-covered service, is reported with CPT codes 97810 – 97814.

Use ICD-10-CM code Z01.89 only when procedure codes 62310, 62311, 62318, 62319 are used for injection of agents for diagnostic procedures unrelated to pain management (e.g., cisternography).

TRIGGER POINT INJECTIONS AND INJECTIONS OF TENDON SHEATH, LIGAMENT, GANGLION CYST, CARPAL AND TARSAL TUNNELS

For trigger point injections, use code 20552 for one or two muscle groups injected, or 20553 for
three or more muscle groups. The number of services for either code is one (1), regardless of the number of injections at any individual site, and regardless of the number of sites. Only 20552 or 20553 may be billed, not both. Trigger point injections must be billed on only one line, regardless of the number of sites.

CPT code 20551 should be used when the origin or insertion of a tendon is injected, in contrast to an injection of the tendon sheath, CPT code 20550.

CPT code 28899 (unilateral procedure, foot or toe) should be billed for the injection of the tarsal tunnel.

Injection of separate sites (tendon sheath, ligament or ganglion cyst) during the same encounter should be reported on a separate line of coding and must have the modifier 59 appended. Multiple surgical rules will apply. Modifier 50 should not be reported with CPT codes 20551, 20552, 20553 or 20612, but may be reported, when appropriate, with CPT codes 20550 and 20526. For an Ambulatory Surgical Center (ASC), the appropriate site modifier (RT and/or LT) should be appended to indicate if the service was performed unilaterally or bilaterally. Bilateral services must be reported on separate lines using an RT and LT modifier (50 modifier should not be used).

Multiple injections per day, at the same site, are considered one injection and should be coded with one unit of service (NOS 001).

Claims for prolotherapy must not be reported with the trigger point codes or other injection codes.

**Epidural and Intrathecal Injections - Interlaminar and Caudal and Treatment of Spasticity**

All the CPT codes applicable to this policy include allowance for the insertion of the needle into the epidural or intrathecal space, as well as the injection of the drug.

The CPT codes 62310, 62311, 62318, and 62319 each have a bilateral surgery indicator of "0." Modifier -50 and/or the anatomic modifiers, -LT/-RT should not be used.

Only one (1) unit of 62310, 62311, 62318 or 62319 should be billed and allowed per spinal region [cervical/thoracic, lumbar/sacral (caudal)], no matter how many injections are made in that region.

**Epidural Injections - Transforaminal**

The CPT codes 64479-64484 have a bilateral surgery indicator of "1." Thus, they are considered "unilateral" procedures and the 150% payment adjustment for bilateral procedures applies. When injecting a nerve root bilaterally, file with modifier –50. When injecting a nerve root unilaterally, file the appropriate anatomic modifier –LT or –RT. For an Ambulatory Surgical Center (ASC), the appropriate site modifier (RT and/or LT) should be appended to indicate if the service was
performed unilaterally or bilaterally. Bilateral services must be reported on separate lines using an RT and LT modifier (50 modifier should not be used).

- Only one (1) unit of service should be submitted for a transforaminal epidural injection for a unilateral or bilateral injection at the same level.

Whether a transforaminal epidural block is performed unilaterally or bilaterally at one vertebral level, use CPT code 64479 or 64483 for the first level injected. If a second level is injected unilaterally or bilaterally, use CPT code 64480 or 64484.

Effective January 1, 2011 fluoroscopic or computed tomography (CT) image guidance and any injection of contrast are inclusive components of CPT codes 64479 – 64484 and should not be separately billed.

PARAVERTEBRAL JOINT/NERVE BLOCKS – DIAGNOSTIC AND THERAPEUTIC

A facet joint level refers to the zygapophyseal joint or the two medial branch nerves innervating that zygapophyseal joint.

Use CPT codes 64491 and 64492 in conjunction with 64490. Do not report CPT code 64492 more than once per day. Use CPT codes 64494 and 64495 in conjunction with 64493. Do not report CPT code 64495 more than once per day. For injection of the T12-L1 joint, or nerves innervating that joint, use 64493.

The CPT codes 64490 and 64493 have a bilateral surgery indicator of "1." Thus, they are considered "unilateral" procedures and the 150% payment adjustment for the bilateral procedures applies.

- When injecting a facet joint/nerve bilaterally, file with modifier –50.
- When injecting a facet joint/nerve unilaterally, file the appropriate anatomic modifier –LT or –RT.
- Only one (1) unit of service (equals one bilateral injection or one unilateral injection) should be submitted for a unilateral or bilateral paravertebral facet joint/nerve injection.
- For an Ambulatory Surgical Center (ASC), the appropriate site modifier (RT and/or LT) should be appended to indicate if the service was performed unilaterally or bilaterally. Bilateral services must be reported on separate lines using an RT and LT modifier (50 modifier should not be used).

Whether a paravertebral facet joint/nerve block is performed unilaterally or bilaterally at one vertebral level, use CPT code 64490 or 64493 for the first level injected. If a second, third or any additional level is injected unilaterally or bilaterally, use CPT codes 64491, 64492, 64494 or 64495.

- Facet joint levels refer to the joints that are blocked and not the number of medial nerve branches that innervate them. The CPT codes 64490 and 64493 are intended to be used to report all of the nerves that innervate the first paravertebral facet joint level injected and
not each nerve. CPT codes 64491, 64492, 64494 or 64495 are intended to report each additional paravertebral facet joint level and not each additional nerve.

For Paravertebral Spinal Nerves and Branches – Image guidance [fluoroscopy or CT] and any injection of contrast are inclusive components of 64490-64495. Do not report CPT codes 64490-64495 unless fluoroscopic- or CT-guidance is performed.

PARAVERTEBRAL JOINT/NERVE DENERVATION

A facet joint is supplied by two medial branch nerves. Each medial branch nerve supplies sensation to one half of each facet joint above and below the spinal nerve of origin. Therefore, both of the two related medial nerve branches for each facet joint must be treated.

Effective January 1, 2012, CPT codes 64622, 64623, 64626, and 64627 were deleted and replaced with 64633, 646434, 64635, and 64636. For Paravertebral Spinal Nerves and Branches – Image guidance [fluoroscopy or CT] and any injection of contrast are inclusive components of 64633-64636. Do not report CPT codes 64633-64636 unless fluoroscopic- or CT-guidance is performed.

The CPT codes 64633, 64634, 64635, 64636 have a bilateral surgery indicator of "1." Thus, they are considered “unilateral” procedures and the 150% payment adjustment for bilateral procedures applies.

- When denervating a facet joint unilaterally, file the appropriate anatomic modifier, –LT or –RT.
- When denervating a facet joint bilaterally file with modifier –50.
- **One (1) unit of service** may be submitted per facet joint. For example, destruction of L3 and L4 medial branch nerves would be coded as 64635.
- For an Ambulatory Surgical Center (ASC), the appropriate site modifier (RT and/or LT) should be appended to indicate if the service was performed unilaterally or bilaterally. Bilateral services must be reported on separate lines using an RT and LT modifier (50 modifier should not be used).

Whether a paravertebral facet joint/nerve denervation is performed unilaterally or bilaterally, use CPT code 64633 or 64635 for the first facet joint denervated. If a second facet joint is denervated unilaterally or bilaterally, use CPT code 64634 or 64636.

Injecting any denervation agent through the needle, including small amounts of contrast or anesthetic to confirm the position of the needle is considered an integral part of the procedure and is not separately reimbursed. Neither the injection procedure nor the anesthetic or denervation agent drugs should be billed.

SACROILIAC (SI) JOINT INJECTIONS

CPT codes 27096 and G0260 should not be billed when a physician provides routine sacroiliac injections. They are to be used only with imaging confirmation of intra-articular needle
positioning.

Effective January 1, 2012 Paravertebral Spinal Nerves and Branches – Image guidance [fluoroscopy or CT] and any injection of contrast are inclusive components of 27096. Do not report CPT code 27096 or G0260 unless fluoroscopic- or CT-guidance is performed.

The CPT code 27096 has a bilateral surgery indicator of "1." Thus, it is considered a "unilateral" procedure. Follow the same guidelines for G0260:

- When injecting a sacroiliac joint bilaterally, file with modifier –50.
- When injecting a sacroiliac joint unilaterally, file the appropriate anatomic modifier –LT or –RT.
- Only one (1) unit of service (equals one bilateral injection or one unilateral injection) should be submitted for a unilateral or bilateral sacroiliac joint/nerve injection.
- For an Ambulatory Surgical Center (ASC), the appropriate site modifier (RT and/or LT) should be appended to indicate if the service was performed unilaterally or bilaterally. Bilateral services must be reported on separate lines using an RT and LT modifier (50 modifier should not be used).

CPT code G0260 should be billed by facilities paid by OPPS.

Do not bill CPT code 73542 (Radiologic examination, sacroiliac joint arthrography, radiological supervision and interpretation) for injection of contrast to verify needle position. The CPT code 73542 is only to be billed for a medically necessary diagnostic study and requires a full interpretation and report.

For claims submitted to the Part B MAC

**TRIGGER POINT INJECTIONS; AND INJECTIONS OF TENDON SHEATH, LIGAMENT, GANGLION CYST, CARPAL AND TARSAL TUNNELS**

Injections of trigger points; and injections of tendon sheaths, ligaments, ganglion cysts, carpal and tarsal tunnels are payable in the following places of service: office (11), home (12), assisted living facility (13), group home/foster care setting (14), temporary lodging (16) urgent care facility (20), inpatient hospital (21), outpatient hospital (22), emergency room (23), ambulatory surgical center (ASC) (24), skilled nursing facility (31), nursing facility (32), custodial care facility (33), independent clinic (49), comprehensive inpatient rehab facility (61), comprehensive outpatient rehab facility (62), end stage renal disease treatment facility (65) and state or local public health clinic (71). Local anesthetics are not separately reimbursed and should not be billed.

**INTERLAMINAR OR CAUDAL EPIDURAL AND/OR INTRATHECAL INJECTIONS INCLUDING THOSE TREATING SPASTICITY, TRANSFORAMINAL EPIDURAL INJECTIONS, PARAVERTEBRAL JOINT/NERVE INJECTIONS AND DENERVATION, AND SACROILIAC JOINT INJECTIONS**
Acceptable places of service are: office (11), inpatient hospital (21), outpatient hospital (22), emergency room (23), ambulatory surgical center (24), skilled nursing facility for patients in a Part A stay (31), skilled nursing facility for patients not in a Part A stay (32), independent clinic (49), comprehensive inpatient rehabilitation facility (61), and comprehensive outpatient rehabilitation facility (62). CPT code G0260 may only be billed in the ambulatory surgery center (POS 24).

All procedures performed at a single encounter should be billed on the same claim. Indicate the level of epidural transforaminal or facet joint/nerves injected/denervated, e.g., C2/3, L5/S1, etc., in Item 19 of the CMS-1500 form or its electronic equivalent. Please also note whether all injections are diagnostic (dx) or therapeutic (tx), if applicable.

Ambulatory surgery centers (ASCs) must append modifier -KX (Requirements in the medical policy have been met) to all procedures for which fluoroscopy- or CT-guidance is medically necessary to attest to the use of such imaging. Procedures requiring medically necessary fluoroscopy- or CT-guidance include transforaminal epidural injections, paravertebral joint/nerve injections or denervations, and sacroiliac joint injections. In addition, subsequent epidural (interlaminar or caudal) injections after a failed or inadequate response to a blind injection, if performed, should be under fluoroscopic visualization or CT-guidance. Effective January 1, 2010, modifier –KX is not required for paravertebral joint/nerve injections. However, the CPT procedures codes 64490-64495 should not be reported unless fluoroscopy or CT guidance is performed.

**HCPCS DRUG CODES**

The HCPCS drug code is payable in the following places of service: office (11), home (12), assisted living facility (13), group home foster care setting (14) temporary lodging (16), urgent care facility (20), nursing facility (32), custodial care facility (33), independent clinic (49), end stage renal disease treatment facility (65) and state or local public health clinic (71).

A claim for services rendered in the inpatient hospital (21), outpatient hospital (22) or emergency room, hospital (23), ambulatory surgery center (24), skilled nursing facility for patients in a Part A stay (31), comprehensive inpatient rehabilitation facility (61), and comprehensive outpatient rehabilitation facility (62) must indicate the name of the drug and dosage in item 19 or the electronic equivalent. The HCPCS drug code and dose is not required when CPT 20612 is reported for aspiration and not for injection or when the ICD-10-CM code reported is 726.32 and there is no injection.

The medication being injected, designated by an appropriate HCPCS drug code must be submitted on the same claim, same day of service as the claim for the procedure. Claims for local anesthetic should not be reported. The exceptions to this guideline are:

- When services are rendered in places of services 21, 22, 23, 61, and 62 there should be no claim for the HCPCS drug code. In addition, drugs packaged in ASC payments should not be separately reported.
A claim for services rendered in the office or independent clinic, when the physician does not bill for the injectables, must include the name of the drug and dosage in item 19 or the electronic equivalent.

**For claims submitted to the Part A MAC**

**Hospital Inpatient Claims:**

- The hospital should report the patient's principal diagnosis in Form Locator (FL) 67 of the UB-04. *The principal diagnosis is the condition established after study to be chiefly responsible for this admission.*
- The hospital enters ICD-10-CM codes for up to eight additional conditions in FLs 67A-67Q if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may not duplicate the principal diagnosis listed in FL 67.
- For inpatient hospital claims, the admitting diagnosis is required and should be recorded in FL 69. (See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25, Section 75 for additional instructions.)

**Hospital Outpatient Claims:**

- *The hospital should report the full ICD-10-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67.* If no definitive diagnosis is made during the outpatient evaluation, the patient’s symptom is reported. If the patient arrives without a referring diagnosis, symptom or complaint, the provider should report an ICD-10-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (Z00.00-Z13.9).
- *The hospital enters the full ICD-10-CM codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.*

All procedures performed at a single encounter must be billed on the same claim. The level of epidural transforaminal or facet joint/nerves injected/denervated, e.g., C2/3, L5/S1, etc., may be indicated in form locator (FL) 80 of the UB-04, or its electronic equivalent. Please also note whether all injections are diagnostic (dx) or therapeutic (tx), if applicable.

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**Coding Information**

**Bill Type Codes:**

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.
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<tr>
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<td>012x</td>
<td>Hospital Inpatient (Medicare Part B only)</td>
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<td>013x</td>
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<td>Hospital - Swing Beds</td>
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<td>085x</td>
<td>Critical Access Hospital</td>
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**Revenue Codes:**

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the article services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

Revenue codes only apply to providers who bill these services to the Part A MAC Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the Part B MAC.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

All revenue codes billed on the inpatient claim for the dates of service in question may be subject to review.

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<td>Emergency Room - General Classification</td>
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<td>INJECTION(S); SINGLE TENDON SHEATH, OR LIGAMENT, APONEUROSIS (EG, PLANTAR &quot;FASCIA&quot;)</td>
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<td>INJECTION(S); SINGLE TENDON ORIGIN/INSERTION</td>
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<td>ASPIRATION AND/OR INJECTION OF GANGLION CYST(S) ANY LOCATION</td>
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<td>28899</td>
<td>UNLISTED PROCEDURE, FOOT OR TOES</td>
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<td>INJECTION(S); SINGLE OR MULTIPLE TRIGGER POINT(S), 3 OR MORE MUSCLE(S)</td>
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**Group 1 Paragraph:**
**TRIGGER POINT INJECTIONS**

**Group 2 Paragraph:**
**INJECTION OF TENDON SHEATHS, LIGAMENTS, GANGLION CYSTS, CARPAL AND TARSAL TUNNELS**

**Group 3 Paragraph:**
**EPIDURAL AND INTRATHECAL INJECTIONS - INTERLAMINAR AND CAUDAL**
### Group 3 Codes:

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### Group 4 Paragraph:

**INTRATHECAL BACLOFEN ADMINISTRATION**

### Group 4 Codes:

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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

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; LUMBAR OR SACRAL (CAUDAL)

62311

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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; LUMBAR OR SACRAL (CAUDAL)

62319

J0475  INJECTION, BACLOFEN, 10 MG

J0476  INJECTION, BACLOFEN, 50 MCG FOR INTRATHECAL TRIAL

Group 5 Paragraph:
EPIDURAL INJECTIONS – TRANSFORAMINAL

Group 5 Codes:

CPT/HCPCS
Codes
Information
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INJECTION(S), ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); CERVICAL OR THORACIC, SINGLE LEVEL

64479

INJECTION(S), ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH IMAGING GUIDANCE

64480
FLUOROSCOPY OR CT); CERVICAL OR THORACIC, EACH ADDITIONAL LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
INJECTION(S), ANESTHETIC AGENT AND/OR STEROID,
TRANSFORAMINAL EPIDURAL, WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); LUMBAR OR SACRAL, SINGLE LEVEL
INJECTION(S), ANESTHETIC AGENT AND/OR STEROID,
TRANSFORAMINAL EPIDURAL, WITH IMAGING GUIDANCE

64483

64484

Group 6 Paragraph:
PARAVERTEBRAL JOINT/NERVE BLOCKS – DIAGNOSTIC AND THERAPEUTIC and PARAVERTEBRAL JOINT/NERVE DENERVATION

Group 6 Codes:

CPT/HCPCS
Codes
Information
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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

64492

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
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)

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; THIRD AND ANY ADDITIONAL LEVEL(S) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

64495

DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE(S), WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); CERVICAL OR THORACIC, SINGLE FACET JOINT

64633

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)

64634

DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE(S), WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); LUMBAR OR SACRAL, SINGLE FACET JOINT

64635

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)

64636

UNLISTED PROCEDURE, NERVOUS SYSTEM

64999

Group 7 Paragraph:
SACROILIAC (SI) JOINT INJECTIONS

Group 7 Codes:

CPT/HCPCS Codes

Information Table

INJECTION PROCEDURE FOR SACROILIAC JOINT, ANESTHETIC/STEROID, WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT) INCLUDING ARTHROGRAPHY WHEN PERFORMED

27096

INJECTION PROCEDURE FOR SACROILIAC JOINT; PROVISION OF ANESTHETIC, STEROID AND/OR OTHER THERAPEUTIC AGENT, WITH OR WITHOUT ARTHROGRAPHY

G0260
ICD-10 Codes that are Covered

ICD-10 Codes that are Not Covered
N/A

Revision History Information

N/A

Associated Documents

Related Local Coverage Document(s)
N/A
Related National Coverage Document(s)
N/A
Statutory Requirements URL(s)
N/A
Rules and Regulations URL(s)
N/A
CMS Manual Explanations URL(s)
N/A
Other URL(s)
N/A
Public Version(s)
Updated on 04/02/2014 with effective dates 10/01/2014 - N/A