# Local Coverage Determination (LCD) for Pain Management (L28529)

**Contractor Name**
National Government Services, Inc.

## 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

CMS Publication 100-03, Medicare National Coverage Determinations (NCD) Manual, Chapter 1:
30.3 Acupuncture
150.7 Prolotherapy, Joint Sclerotherapy, and Ligamentous Injections with Sclerosing Agents
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, spondylolisthesis, spondylolysis, 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 location on a single date of service.

**EPIDURAL AND INTRATHECAL INJECTIONS: INTERLAMINAR AND CAUDAL AND TREATMENT OF SPASTICITY**

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-decompressed 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.

The CPT code 72275 (Epidurography, radiological supervision and interpretation) differs from CPT code 77003 in that it 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 Determination 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 (NPs) may only perform procedures requiring radiologic imaging if their respective states allow such in their practice act and license the practitioner to use radiation.

Other Comments:

For claims submitted to the fiscal intermediary Part A MAC: this coverage determination also applies within states outside the primary geographic jurisdiction with facilities that have nominated National Government Services to process their claims.

Bill type codes only apply to providers who bill these services to the fiscal intermediary or Part A MAC. Bill type codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier Part B MAC.

For dates of service prior to April 1, 2010, FQHC services should be reported with bill type 73X.
For dates of service on or after April 1, 2010, bill type 77X should be used to report FQHC services.

Limitation of liability and refund requirements apply when denials are anticipated, whether based on medical necessity or other coverage reasons. The provider/supplier must notify the beneficiary in writing, prior to rendering the service, if the provider/supplier is aware that the test, item or procedure may not be covered by Medicare. The limitation of liability and refund requirements do not apply when the test, item or procedure is statutorily excluded, has no Medicare benefit category or is rendered for screening purposes.

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.

011x Hospital Inpatient (Including Medicare Part A)
012x Hospital Inpatient (Medicare Part B only)
013x Hospital Outpatient
018x Hospital - Swing Beds
021x Skilled Nursing - Inpatient (Including Medicare Part A)
022x Skilled Nursing - Inpatient (Medicare Part B only)
023x Skilled Nursing - Outpatient
071x Clinic - Rural Health
073x Clinic - Freestanding
075x Clinic - Comprehensive Outpatient Rehabilitation Facility (CORF)
077x Clinic - Federally Qualified Health Center (FQHC)
085x Critical Access Hospital

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 fiscal intermediary or Part A MAC. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>0360</td>
<td>Operating Room Services - General Classification</td>
</tr>
<tr>
<td>0450</td>
<td>Emergency Room - General Classification</td>
</tr>
<tr>
<td>049X</td>
<td>Ambulatory Surgical Care - General Classification</td>
</tr>
<tr>
<td>050X</td>
<td>Outpatient Services - General Classification</td>
</tr>
<tr>
<td>051X</td>
<td>Clinic - General Classification</td>
</tr>
<tr>
<td>052X</td>
<td>Free-Standing Clinic - General Classification</td>
</tr>
<tr>
<td>0761</td>
<td>Specialty Services - Treatment Room</td>
</tr>
<tr>
<td>096X</td>
<td>Professional Fees - General Classification</td>
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CPT/HCPCS Codes

TRIGGER POINT INJECTIONS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>20552</td>
<td>INJECTION(S); SINGLE OR MULTIPLE TRIGGER POINT(S), 1 OR 2 MUSCLE(S)</td>
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<tr>
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<td>INJECTION(S); SINGLE OR MULTIPLE TRIGGER POINT(S), 3 OR MORE MUSCLE(S)</td>
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INJECTION OF TENDON SHEATHS, LIGAMENTS, GANGLION CYSTS, CARPAL AND TARSAL TUNNELS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>20526</td>
<td>INJECTION, THERAPEUTIC (EG, LOCAL ANESTHETIC, CORTICOSTEROID), CARPAL TUNNEL</td>
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<tr>
<td>20550</td>
<td>INJECTION(S); SINGLE TENDON SHEATH, OR LIGAMENT, APONEUROSIS (EG, PLANTAR “FASCIA”)</td>
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<tr>
<td>20551</td>
<td>INJECTION(S); SINGLE TENDON ORIGIN/INSERTION</td>
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<tr>
<td>20612</td>
<td>ASPIRATION AND/OR INJECTION OF GANGLION CYST(S)</td>
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<tr>
<td></td>
<td>ANY LOCATION</td>
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<tr>
<td>28899</td>
<td>UNLISTED PROCEDURE, FOOT OR TOES</td>
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EPIDURAL AND INTRATHECAL INJECTIONS - INTERLAMINAR AND CAUDAL

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<td>01996</td>
<td>DAILY HOSPITAL MANAGEMENT OF EPIDURAL OR SUBARACHNOID CONTINUOUS DRUG ADMINISTRATION 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</td>
</tr>
<tr>
<td>62310</td>
<td>INJECTION(S); SINGLE OR MULTIPLE TRIGGER POINT(S), 1 OR 2 MUSCLE(S)</td>
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<td></td>
<td>INJECTION(S); SINGLE OR MULTIPLE TRIGGER POINT(S), 3 OR MORE MUSCLE(S)</td>
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</tbody>
</table>

INJECTION, THERAPEUTIC (EG, LOCAL ANESTHETIC, CORTICOSTEROID), CARPAL TUNNEL
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)

EPIDURAL INJECTIONS – TRANSFORAMINAL

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

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

EPIDURAL AND INTRATHECAL INJECTIONS - ACUTE POST-OPERATIVE CARE MANAGEMENT
01996  DAILY HOSPITAL MANAGEMENT OF EPIDURAL OR SUBARACHNOID CONTINUOUS DRUG ADMINISTRATION 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)

PARAVERTEBRAL JOINT/NERVE BLOCKS (DIAGNOSTIC AND THERAPEUTIC) 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)

64492 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

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; 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 PARAVERTEBRAL JOINT/NERVE DENERVATION
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
SACROILIAC (SI) JOINT INJECTIONS

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

INJECTION PROCEDURE FOR SACROILIAC JOINT;

PROVISION OF ANESTHETIC, STEROID AND/OR OTHER THERAPEUTIC AGENT, WITH OR WITHOUT ARTHROGRAPHY

INTRATHECAL DRUGS

J0475 INJECTION, BACLOFEN, 10 MG
J0476 INJECTION, BACLOFEN, 50 MCG FOR INTRATHECAL TRIAL
J0735 INJECTION, CLONIDINE HYDROCHLORIDE, 1 MG
J1170 INJECTION, HYDROMORPHONE, UP TO 4 MG
J2275 INJECTION, MORPHINE SULFATE (PRESERVATIVE-FREE STERILE SOLUTION), PER 10 MG
J2278 INJECTION, ZICONOTIDE, 1 MICROGRAM
J3010 INJECTION, FENTANYL CITRATE, 0.1 MG
J3490 UNCLASSIFIED DRUGS

FLUOROSCOPIC GUIDANCE OR CT GUIDANCE

The following codes should be reported as indicated.

FLUOROSCOPIC GUIDANCE AND LOCALIZATION OF NEEDLE OR CATHETER TIP FOR SPINE OR PARASPINOUS DIAGNOSTIC OR THERAPEUTIC INJECTION PROCEDURES (EPIDURAL OR SUBARACHNOID)

77003 COMPUTED TOMOGRAPHY GUIDANCE FOR NEEDLE PLACEMENT (EG, BIOPSY, ASPIRATION, INJECTION, LOCALIZATION DEVICE), RADIOLOGICAL SUPERVISION AND INTERPRETATION

ICD-9 Codes that Support Medical Necessity

It is the responsibility of the provider to code to the highest level specified in the ICD-9-CM (e.g., to the fourth or fifth digit). The correct use of an ICD-9-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)

729.1 MYALGIA AND MYOSITIS UNSPECIFIED
INJECTION OF TENDON SHEATHS, LIGAMENTS, GANGLION CYSTS, CARPAL AND TARSAL TUNNELS (CPT codes 20526, 20550, 20551, 20612, 28899 [use for tarsal tunnel injections])
354.0 CARPAL TUNNEL SYNDROME
355.5 TARSAL TUNNEL SYNDROME
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>720.1</td>
<td>SPINAL ENTHESOPATHY</td>
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<tr>
<td>726.0</td>
<td>ADHESIVE CAPSULITIS OF SHOULDER</td>
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<tr>
<td>726.10</td>
<td>DISORDERS OF BURSAE AND TENDONS IN SHOULDER REGION UNSPECIFIED</td>
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<tr>
<td>726.11</td>
<td>CALCIFYING TENDINITIS OF SHOULDER</td>
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<td>726.12</td>
<td>BICIPITAL TENOSYNOVITIS</td>
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<td>726.19</td>
<td>OTHER SPECIFIED DISORDERS OF BURSAE AND TENDONS IN SHOULDER REGION</td>
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<td>OTHER AFFECTIONS OF SHOULDER REGION NOT ELSEWHERE CLASSIFIED</td>
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<td>726.30</td>
<td>ENTHESOPATHY OF ELBOW UNSPECIFIED</td>
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<tr>
<td>726.31</td>
<td>MEDIAL EPICONDYLITIS</td>
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<td>726.32</td>
<td>LATERAL EPICONDYLITIS</td>
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<td>OLECRANON BURSITIS</td>
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<td>726.39</td>
<td>OTHER ENTHESOPATHY OF ELBOW REGION</td>
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<td>726.4</td>
<td>ENTHESOPATHY OF WRIST AND CARPUS</td>
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<tr>
<td>726.5</td>
<td>ENTHESOPATHY OF HIP REGION</td>
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<tr>
<td>726.60</td>
<td>ENTHESOPATHY OF KNEE UNSPECIFIED</td>
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<td>726.61</td>
<td>PES ANSERINUS TENDINITIS OR BURSITIS</td>
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<td>726.63</td>
<td>FIBULAR COLLATERAL LIGAMENT BURSITIS</td>
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<td>PREPATELLAR BURSITIS</td>
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<td>OTHER ENTHESOPATHY OF KNEE</td>
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<td>726.70</td>
<td>ENTHESOPATHY OF ANKLE AND TARSUS UNSPECIFIED</td>
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<td>ACHILLES BURSITIS OR TENDINITIS</td>
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<td>TIBIALIS TENDINITIS</td>
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<td>OTHER ENTHESOPATHY OF ANKLE AND TARSUS</td>
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<td>OTHER PERIPHERAL ENTHESOPATHIES</td>
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<td>SYNOVITIS AND TENOSYNOVITIS UNSPECIFIED</td>
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<td>SYNOVITIS AND TENOSYNOVITIS IN DISEASES CLASSIFIED ELSEWHERE</td>
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<td>GIANT CELL TUMOR OF TENDON SHEATH</td>
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<td>727.2</td>
<td>SPECIFIC BURSITIDES OFTEN OF OCCUPATIONAL ORIGIN</td>
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727.3* OTHER BURSITIS DISORDERS
727.40 SYNOVIAL CYST UNSPECIFIED
727.41 GANGLION OF JOINT
727.42 GANGLION OF TENDON SHEATH
727.43 GANGLION UNSPECIFIED
728.6 CONTRACTURE OF PALMAR FASCIA
728.71 PLANTAR FASCIAL FIBROMATOSIS
728.79 OTHER FIBROMATOSES OF MUSCLE LIGAMENT AND FASCIA
729.4 FASCIITIS UNSPECIFIED
*Use ICD-9-CM code 726.73 for heel pain syndrome
*Use ICD-9-CM code 726.79 for calcaneal bursitis
*Use ICD-9-CM code 727.3 for bursitis in the foot
EPI DURAL AND INTRATHECAL INJECTIONS: INTERLAMINAR AND CAUDAL (CPT codes 62310, 62311, 62318, 62319)
053.10 HERPES ZOSTER WITH UNSPECIFIED NERVOUS SYSTEM COMPLICATION
053.13 POSTHERPETIC POLYNEUROPATHY
053.19 HERPES ZOSTER WITH OTHER NERVOUS SYSTEM COMPLICATIONS
322.2 CHRONIC MENINGITIS
337.21 REFLEX SYMPATHETIC DYSTROPHY OF THE UPPER LIMB
337.22 REFLEX SYMPATHETIC DYSTROPHY OF THE LOWER LIMB
337.29 REFLEX SYMPATHETIC DYSTROPHY OF OTHER SPECIFIED SITE
338.11 ACUTE PAIN DUE TO TRAUMA
338.12 ACUTE POST-T ORACOTOMY PAIN
338.18 OTHER ACUTE POSTOPERATIVE PAIN
338.21 CHRONIC PAIN DUE TO TRAUMA
338.22 CHRONIC POST-T ORACOTOMY PAIN
338.28 OTHER CHRONIC POSTOPERATIVE PAIN
338.3 NEOPLASM RELATED PAIN (ACUTE) (CHRONIC)
353.2 CERVICAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.3 THORACIC ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.4 LUMBOSACRAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.6 PHANTOM LIMB (SYNDROME)
354.4 CAUSALGIA OF UPPER LIMB
355.71 CAUSALGIA OF LOWER LIMB
721.0 CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY
721.1 CERVICAL SPONDYLOSIS WITH MYELOPATHY
721.2 THORACIC SPONDYLOSIS WITHOUT MYELOPATHY
721.3 LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY
721.41 SPONDYLOSIS WITH MYELOPATHY THORACIC REGION
721.42 SPONDYLOSIS WITH MYELOPATHY LUMBAR REGION
721.90 SPONDYLOSIS OF UNSPECIFIED SITE WITHOUT MYELOPATHY
721.91 SPONDYLOSIS OF UNSPECIFIED SITE WITH MYELOPATHY
722.0 DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.10 DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.11 DISPLACEMENT OF THORACIC INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.2 DISPLACEMENT OF INTERVERTEBRAL DISC SITE UNSPECIFIED WITHOUT MYELOPATHY
722.4 DEGENERATION OF CERVICAL INTERVERTEBRAL DISC
722.51 DEGENERATION OF THORACIC OR THORACOLUMBAR INTERVERTEBRAL DISC
722.52 DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
722.71 INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY CERVICAL REGION
722.72 INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY THORACIC REGION
722.73 INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY LUMBAR REGION
722.81 POSTLAMINECTOMY SYNDROME OF CERVICAL REGION
722.82 POSTLAMINECTOMY SYNDROME OF THORACIC REGION
722.83 POSTLAMINECTOMY SYNDROME OF LUMBAR REGION
723.0 SPINAL STENOSIS IN CERVICAL REGION
723.4 BRACHIAL NEURITIS OR RADICULITIS NOS
724.01 SPINAL STENOSIS OF THORACIC REGION
724.02 SPINAL STENOSIS, LUMBAR REGION, WITHOUT NEUROGENIC CLAUDICATION
724.03 SPINAL STENOSIS, LUMBAR REGION, WITH NEUROGENIC CLAUDICATION
724.3 SCIATICA
724.4 THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS UNSPECIFIED
733.13 PATHOLOGICAL FRACTURE OF VERTEBRAE
738.4 ACQUIRED SPONDYLOLISTHESIS
756.12 SPONDYLOLISTHESIS CONGENITAL
953.0 INJURY TO CERVICAL NERVE ROOT
953.1 INJURY TO DORSAL NERVE ROOT
953.2 INJURY TO LUMBAR NERVE ROOT
953.3 INJURY TO SACRAL NERVE ROOT
V58.61* LONG-TERM (CURRENT) USE OF ANTICOAGULANTS
V72.5* RADIOLOGICAL EXAMINATION NOT ELSEWHERE CLASSIFIED
*Use ICD-9-CM code V72.5 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 V58.61 only as a supplemental code in addition to primary diagnosis, when anticoagulant therapy has been discontinued to facilitate therapeutic injections for pain management.)

EPI DURAL INJECTION S – TRANS FORAMINAL (64479, 64480, 64483, 64484)

053.10 HERPES ZOSTER WITH UNSPECIFIED NERVOUS SYSTEM COMPLICATION
053.13 POSTHERPETIC POLYNEUROPATHY
053.19 HERPES ZOSTER WITH OTHER NERVOUS SYSTEM COMPLICATIONS
338.21 CHRONIC PAIN DUE TO TRAUMA
338.22 CHRONIC POST-THORACOTOMY PAIN
338.28 OTHER CHRONIC POSTOPERATIVE PAIN
338.3 NEOPLASM RELATED PAIN (ACUTE) (CHRONIC)
353.2 CERVICAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.3 THORACIC ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.4 LUMBOSACRAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
721.0 CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY
721.1 CERVICAL SPONDYLOSIS WITH MYELOPATHY
721.2 THORACIC SPONDYLOSIS WITHOUT MYELOPATHY
721.3 LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY
721.41 SPONDYLOSIS WITH MYELOPATHY THORACIC REGION
721.42 SPONDYLOSIS WITH MYELOPATHY LUMBAR REGION
721.90 SPONDYLOSIS OF UNSPECIFIED SITE WITHOUT MYELOPATHY
721.91 SPONDYLOSIS OF UNSPECIFIED SITE WITH MYELOPATHY
722.0 DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.10 DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.11 DISPLACEMENT OF THORACIC INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.2 DISPLACEMENT OF INTERVERTEBRAL DISC SITE UNSPECIFIED WITHOUT MYELOPATHY
722.4 DEGENERATION OF CERVICAL INTERVERTEBRAL DISC
722.51 DEGENERATION OF THORACIC OR THORACOLUMBAR INTERVERTEBRAL DISC
722.52 DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
722.71 INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY CERVICAL REGION
722.72 INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY THORACIC REGION
722.73 INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY LUMBAR REGION
722.81 POSTLAMINECTOMY SYNDROME OF CERVICAL REGION
722.82 POSTLAMINECTOMY SYNDROME OF THORACIC REGION
722.83 POSTLAMINECTOMY SYNDROME OF LUMBAR REGION
723.0 SPINAL STENOSIS IN CERVICAL REGION
723.4 BRACHIAL NEURITIS OR RADICULITIS NOS
724.01 SPINAL STENOSIS OF THORACIC REGION
724.02 SPINAL STENOSIS, LUMBAR REGION, WITHOUT NEUROGENIC CLAUDICATION
724.03 SPINAL STENOSIS, LUMBAR REGION, WITH NEUROGENIC CLAUDICATION
724.3 SCIATICA
724.4 THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS UNSPECIFIED
733.13 PATHOLOGICAL FRACTURE OF VERTEBRAE
953.0 INJURY TO CERVICAL NERVE ROOT
953.1 INJURY TO DORSAL NERVE ROOT
953.2 INJURY TO LUMBAR NERVE ROOT
953.3 INJURY TO SACRAL NERVE ROOT

EPI DURAL AND INTRATHecal INJECTIONS – ACUTE POST-OPERATIVE CARE MANAGEMENT (CPT codes 01996, 62310, 62311, 62318, 62319)

338.11 ACUTE PAIN DUE TO TRAUMA
338.12 ACUTE POST-THOR ACOTOMY PAIN
338.18 OTHER ACUTE POSTOPERATIVE PAIN
338.19* OTHER ACUTE PAIN

*Use ICD-9-CM code 338.19 for obstetric pain management.

INTRATHecal BACLOFEN ADMINISTRATION (01996, 62310, 62311, 62318, 62319, J0475, J0476)

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

333.79 OTHER ACQUIRED TORSION DYSTONIA
334.1 HEREDITARY SPASTIC PARAPLEGIA
336.1 VASCULAR MYELOPATHIES
340 MULTIPLE SCLEROSIS
342.11 SPASTIC HEMIPLEGIA AND HEMIPARESIS AFFECTING DOMINANT SIDE
342.12 SPASTIC HEMIPLEGIA AND HEMIPARESIS AFFECTING NONDOMINANT SIDE
343.0 CONGENITAL DIPLEGIA
343.1 CONGENITAL HEMIPLEGIA
343.2 CONGENITAL QUADRIPLEGIA
343.3 CONGENITAL MONOPOLEGIA
343.4 INFANTILE HEMIPLEGIA
343.8 OTHER SPECIFIED INFANTILE CEREBRAL PALSY
343.9 INFANTILE CEREBRAL PALSY UNSPECIFIED
344.00 QUADRIPLEGIA UNSPECIFIED
344.01 QUADRIPLEGIA C1-C4 COMPLETE
344.02 QUADRIPLEGIA C1-C4 INCOMPLETE
344.03 QUADRIPLEGIA C5-C7 COMPLETE
344.04 QUADRIPLEGIA C5-C7 INCOMPLETE
344.09 OTHER QUADRIPLEGIA
344.1 PARAPLEGIA
344.2 DIPLEGIA OF UPPER LIMBS
344.31 MONOPOLEGIA OF LOWER LIMB AFFECTING DOMINANT SIDE
344.32 MONOPOLEGIA OF LOWER LIMB AFFECTING NONDOMINANT SIDE
344.41 MONOPOLEGIA OF UPPER LIMB AFFECTING DOMINANT SIDE
344.42 MONOPOLEGIA OF UPPER LIMB AFFECTING NONDOMINANT SIDE
344.60 CAUDA EQUINA SYNDROME WITHOUT NEUROGENIC BLADDER
344.61 CAUDA EQUINA SYNDROME WITH NEUROGENIC BLADDER
344.81 LOCKED-IN STATE
344.89 OTHER SPECIFIED PARALYTIC SYNDROME
PARAVERTEBRAL JOINT/NERVE BLOCKS – DIAGNOSTIC AND THERAPEUTIC (CPT codes 64490, 64491, 64492, 64493, 64494, 64495) and PARAVERTEBRAL JOINT/NERVE DENERVATION (CPT codes 64633, 64634, 64635, 64636, 64999)
716.98* UNSPECIFIED ARTHROPATHY INVOLVING OTHER SPECIFIED SITES
721.0 CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY
721.1 CERVICAL SPONDYLOSIS WITH MYELOPATHY
721.2 THORACIC SPONDYLOSIS WITHOUT MYELOPATHY
721.3 LUMBOSacRAL SPONDYLOSIS WITHOUT MYELOPATHY
721.41 SPONDYLOSIS WITH MYELOPATHY THORACIC REGION
721.42 SPONDYLOSIS WITH MYELOPATHY LUMBAR REGION
733.82* NONUNION OF FRACTURE
847.0* NECK SPRAIN
847.1 THORACIC SPRAIN
847.2 LUMBAR SPRAIN
V58.61* LONG-TERM (CURRENT) USE OF ANTICOAGULANTS

* Use ICD-9-CM code 716.98 for facet arthropathy.
* Use ICD-9-CM code 733.82 for patients with pseudoarthrosis.
* Use ICD-9-CM code 847.0 for whiplash and associated cervicogenic headache.

** Use V58.61 only as a supplemental code in addition to primary diagnosis, when anticoagulant therapy has been discontinued to facilitate therapeutic injections for pain management.

SACROILIAC (SI) JOINT INJECTIONS (CPT codes 27096, G0260)

716.95 UNSPECIFIED ARTHROPATHY INVOLVING PELVIC REGION AND THIGH
720.2 SACROILIITIS NOT ELSEWHERE CLASSIFIED
724.6 DISORDERS OF SACRUM
V58.61* LONG-TERM (CURRENT) USE OF ANTICOAGULANTS

* Use V58.61 only as a supplemental code in addition to primary diagnosis, when anticoagulant therapy has been discontinued to facilitate therapeutic injections for pain management.

Diagnoses that Support Medical Necessity
Not applicable

ICD-9 Codes that DO NOT Support Medical Necessity
Not applicable

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity
Not applicable

Documentations 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;
  - Patient education;
  - 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 **acute post-operative pain management** the following lists specific requirements:

Each claim must be submitted with ICD-9-CM codes that reflect the condition of the patient, and indicate the reason(s) for which the service was performed. Claims submitted without ICD-9-CM codes will be returned.

The operative report and record of anesthesia care must be maintained in the patient’s medical record. Documentation of daily services by the anesthesiologist must be available in the medical record.

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 >/= 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.
- 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.

Acute Post Operative Pain Management:

Daily management of epidural or subarachnoid drug administration (CPT code 01996) for the management of post-operative pain is commonly utilized for one (1) to three (3) days after the surgery (up to three days, not including the day of the catheter insertion).

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.

American Society of Anesthesiologists. Practice guidelines for cancer pain management.


Carrier Advisory Committee

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


**Advisory Committee Meeting Notes**

Carrier Advisory Committee Meeting Date(s):

- Connecticut: 09/16/2008
- Indiana: 09/22/2008
- Kentucky: 09/25/2008
- New York: 09/10/2008

This coverage determination does not reflect the sole opinion of the contractor or contractor Medical Director. Although the final decision rests with the contractor, this determination is developed in consultation with representatives from Advisory Committee members and/or from various state and local provider organizations.

**Start Date of Comment Period**

09/02/2008

**End Date of Comment Period**

10/16/2008

**Start Date of Notice Period**

06/01/2011

**Revision History Number**

R12

**Revision History Explanation**

R12 (effective 05/10/2012): Annual LCD review per CMS *Program Integrity Manual*, Chapter 13, Section 13.4[C]. The entire policy was reviewed: The “CMS National Coverage Policy” section and references throughout the text have been updated to reflect the CMS Online Manual System. A statement has been added to the bottom of the “Abstract” to please review each section of the LCD for complete coverage detail. CPT code 01966 was inadvertently added to the CPT code section for EPIDURAL AND INTRATHECAL INJECTIONS - INTERLAMINAR AND CAUDAL. This has been corrected to CPT code 01996. Some of the references in the “Sources of Information” section have been updated. Minor changes were made to reflect current template language. No notice given and none required.

R11 (effective 01/01/2012): CPT codes 64622, 64623, 64626, and 646427 were deleted from the coding Group for PARAVERTEBRAL JOINT/NERVE BLOCKS – DIAGNOSTIC AND THERAPEUTIC and PARAVERTEBRAL JOINT/NERVE DENERVATION and replaced with CPT codes 64633, 64634, 64635, 64636 and throughout the policy. Descriptors were updated for 27096, 62310, 62311, 62318, 62319, 64479, 64480, 64483, 64484, and 77003. The
supplemental instructions article associated with this policy was similarly updated. No notice given and none required.

10/17/2011 - In accordance with Section 911 of the Medicare Modernization Act of 2003, fiscal intermediary numbers 00160 and 00332 are removed from this LCD. Effective on this date, claims processing for Kentucky – Part A and Ohio –Part A is performed by CGS Administrators, LLC, the Part A/Part B MAC contractor for these states.

R10 (effective 08/01/2011): ICD-9 codes 721.0, 721.1, 721.2, 721.3, 721.41, 721.42, 721.90, and 721.91 were added as acceptable diagnoses for claims submitted with CPT codes 62310, 62311, 62318, 62319 (EPIDURAL AND INTRATHECAL INJECTIONS: INTERLAMINAR AND CAUDAL) and CPT codes 64479, 64480, 64483 and 64484 (EPIDURAL INJECTIONS – TRANSFORAMINAL). No notice given and none required.

R9 (effective 06/01/2011): The ICD-9 Codes that Support Medical Necessity diagnosis list for INJECTION OF TENDON SHEATHS, LIGAMENTS, GANGLION CYSTS, CARPAL AND TARSAL TUNNELS (CPT codes 20526, 20550, 20551, 20612, 28899 [use for tarsal tunnel injections]) was updated to add ICD-9-CM code 727.43 (Ganglion, unspecified) as an acceptable diagnosis. No comment period given and none required.

05/16/2011 - In accordance with Section 911 of the Medicare Modernization Act of 2003, fiscal intermediary number 00453 is removed from this LCD. Effective on this date, claims processing for Virginia and West Virginia is performed by Palmetto Government Benefits Administration, the Part A/Part B MAC contractor for these states.

04/30/2011 - In accordance with Section 911 of the Medicare Modernization Act of 2003, carrier number 00660 is removed from this LCD. Effective on this date, claims processing for Kentucky is performed by Cigna Government Services, the Part A/Part B MAC contractor for this state.

R8 (effective 10/01/2010): LCD revised for annual ICD-9-CM code updates for 2011. The “ICD-9-CM Codes That Support Medical Necessity” section of the policy is expanded with the addition of new ICD-9 code 724.03 for CPT codes 62310, 62311, 62318, 62319, 64479, 64480, 64483, and 64484. The descriptor for ICD-9 code 724.02 was revised. Minor changes were made to reflect current template language. No comment period required and none given.

R7 (effective 08/01/2010): The CPT code list for EPIDURAL AND INTRATHECAL INJECTIONS - INTERLAMINAR AND CAUDAL; EPIDURAL INJECTIONS – TRANSFORAMINAL; ACUTE POST-OPERATIVE CARE MANAGEMENT was deleted and replaced with separate lists for EPIDURAL AND INTRATHECAL INJECTIONS - INTERLAMINAR AND CAUDAL; EPIDURAL INJECTIONS – TRANSFORAMINAL; EPIDURAL AND INTRATHECAL INJECTIONS - ACUTE POST-OPERATIVE CARE MANAGEMENT; and INTRATHECAL DRUGS. No new CPT/HCPCS codes were added to the policy, and this does not represent a coding change. The SIA associated with this policy was similarly updated.

The diagnosis list for Epidural and Intrathecal Injections: Interlaminar or Caudal (CPT codes 62310, 62311, 62318, 62319) and Transforaminal (64479, 64480, 64483, 64484); Intrathecal Drugs (J0735, J1170, J2275, J2278, J3010, and J3490) was deleted and replaced by new diagnosis lists developed specifically for EPIDURAL AND INTRATHECAL INJECTIONS: INTERLAMINAR AND CAUDAL (CPT codes 62310, 62311, 62318, 62319); EPIDURAL INJECTIONS – TRANSFORAMINAL (64479, 64480, 64483, and 64484); EPIDURAL AND INTRATHECAL INJECTIONS - ACUTE POST-OPERATIVE CARE MANAGEMENT; and
INTRATHECAL DRUGS. This does not represent a coding change. All diagnosis codes were previously on the policy for each specific type of injection. Other minor changes were made to update for current NGS and CMS template language and correct minor typographical errors. No notice given and none required.

R6 (effective 06/01/2010): Indications for Transforaminal Epidural Injections were updated to replace “local anesthetic” with “injectate” as follows: The diagnostic usefulness is lost if more than 1.0 ml of anesthetic to adjacent levels and structures likely occurs). The Documentation section listing specific requirements for SI Joint Injections was updated to replace “local anesthetic” with “injectate” as follows: 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. A typographical error was corrected to add G0260 in the title of the ICD-9 Coding list for Sacroiliac (SI) Joint Injections (CPT code 27096, G0260). This does not represent a coding change. No comment and notice periods required and none given.

R5 (effective date 05/01/2010): The “ICD-9 Codes that Support Medical Necessity” section for Intrathecal Baclofen Administration was updated to add CPT codes 01996, 62310, 62311, 62318, 62319 as applicable to the existing diagnosis list. Although the revision effective date for the addition of these CPT codes is 05/01/2010, they will be applicable to claims submitted for dates of service from the original effective date of this LCD (01/01/2009). The policy was reviewed and minor cosmetic changes were made to update for current NGS and CMS template language and correct sources of information. TOB 83x was removed. No comment and notice were given as none was required. The SIA associated with this policy was also updated.

R4 (effective date 03/01/2010): Correction of typographical error - Title for the ICD-9-CM coding list for “Paravertebral Joint/Nerve Blocks – Diagnostic and Therapeutic (CPT codes 64490, 64491, 64492, 64493, 64494, 64495) and Paravertebral Joint/Nerve Denervation (CPT codes 64622, 64623, 64626, 64627, 64999)” was corrected to remove deleted codes for Paravertebral Joint/Nerve Blocks – Diagnostic and Therapeutic (64470, 64472, 64475, 64476) and replace with correct codes (64490, 64491, 64492, 64493, 64494, 64495) as shown. Although the revision effective date is 03/01/2010, these codes were effective on or after 01/01/2010.

R3 (effective date 01/01/2010): CPT/HCPCS coding update 2010 - CPT codes 64470, 64472 were deleted from group 4 (PARAVERTEBRAL JOINT/NERVE BLOCKS – DIAGNOSTIC AND THERAPEUTIC) and replaced with CPT codes 64490, 64491, 64492. CPT codes 64475, 64476 were deleted from group 4 (PARAVERTEBRAL JOINT/NERVE BLOCKS – DIAGNOSTIC AND THERAPEUTIC) and replaced with CPT codes 64493, 64494, 64495. The code descriptor was changed for CPT code 77003. The LCD was updated throughout to remove references to deleted codes and update for new codes.

The following guideline was added to the Indications for Paravertebral Facet Joint/Nerve Block: "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 – Fluoroscopic or computed tomography (CT) image guidance [fluoroscopy or CT] and any injection of contrast are inclusive components of 64490-64495.” Based on CR 6338, Change Type of Bill (TOB) for Federally Qualified Health Centers (FQHCs) from 73x to 77x, the following paragraph has been added to the “Other Comments” section of the LCD: “For dates of service prior to April 1, 2010, FQHC services should be reported with bill type 73X. For dates of service on or after April 1, 2010, bill type 77X should be used to report FQHC services.”
Minor changes were made to reflect current template language. No comment period required and none given. The SIA associated with this policy was similarly updated.

R2 (effective date 10/01/2009): Source of Revision – CMS publication.

The CMS National Coverage Policy references were updated to include CMS Transmittal No. 526, Publication 100-20, One-Time Notification, Change Request #6518, July 31, 2009, which updates requirements for the “Appropriate Use of Modifier 50 and Add-On Codes for Facet Joint Injections Services.” No updates to the policy were required to implement this requirement. Minor modifications were made to the policy to reflect updated NGS template language. No change was made to the supplemental instructions article associated with this local coverage determination.

06/05/2009 - In accordance with Section 911 of the Medicare Modernization Act of 2003, fiscal intermediary number 00270 was removed from this LCD as the claims processing for New Hampshire and Vermont was transitioned to NHIC, the Part A/Part B MAC contractor in these states.

05/15/2009 - In accordance with Section 911 of the Medicare Modernization Act of 2003, fiscal intermediary numbers 00180 and 00181 were removed from this LCD as the claims processing for Maine and Massachusetts was transitioned to NHIC, the Part A/Part B MAC contractor in these states.

R1 (effective date 04/01/2009): Source of Revision – External. The ICD-9 Codes that Support Medical Necessity has been revised as follows: In the section describing "Epidural and Intrathecal Injections: Interlaminar or Caudal (CPT codes 62310, 62311, 62318, 62319) and Transforaminal (64479, 64480, 64483, 64484); Intrathecal Drugs" the incorrect intrathecal drug codes J0785 and J1870 (typographical errors) were deleted and replaced with the correct codes HCPCS codes J0735 and J1170. The following statement was revised to add CPT codes 62318, and 62319 – "ICD-9-CM code V72.5 only when procedure codes 62310, 62311, 62318, 62319 are used for injection of agents for diagnostic procedures unrelated to pain management (e.g., cisternography)."

The section describing "Intrathecal Baclofen Administration" was updated by adding J0475 and J0476 to the title. In addition the policy was corrected for other minor typographical errors and to update for current NGS template.

Other minor formatting changes to correct typographical errors and update for current template were made to this supplemental instructions article.

The changes listed in this revision do NOT apply to the states of Maine (contract 00180), Massachusetts (contract 00181), or Vermont and New Hampshire (contract 00270); however, all other instructions, coverage provisions, and requirements in the LCD remain in effect for these states.

11/15/2009 - The description for CPT/HCPCS code 77003 was changed in group 7
11/15/2009 - CPT/HCPCS code 64470 was deleted from group 4
11/15/2009 - CPT/HCPCS code 64472 was deleted from group 4
11/15/2009 - CPT/HCPCS code 64475 was deleted from group 4
11/15/2009 - CPT/HCPCS code 64476 was deleted from group 4

3/7/2010 - The description for Bill Type Code 73 was changed
3/7/2010 - The description for Bill Type Code 77 was changed

8/1/2010 - The description for Bill Type Code 11 was changed
8/1/2010 - The description for Bill Type Code 12 was changed
8/1/2010 - The description for Bill Type Code 13 was changed
8/1/2010 - The description for Bill Type Code 18 was changed
8/1/2010 - The description for Bill Type Code 21 was changed
8/1/2010 - The description for Bill Type Code 22 was changed
8/1/2010 - The description for Bill Type Code 23 was changed
8/1/2010 - The description for Bill Type Code 71 was changed
8/1/2010 - The description for Bill Type Code 73 was changed
8/1/2010 - The description for Bill Type Code 75 was changed
8/1/2010 - The description for Bill Type Code 85 was changed

8/1/2010 - The description for Revenue code 0360 was changed
8/1/2010 - The description for Revenue code 0450 was changed
8/1/2010 - The description for Revenue code 0490 was changed
8/1/2010 - The description for Revenue code 0499 was changed
8/1/2010 - The description for Revenue code 0500 was changed
8/1/2010 - The description for Revenue code 0509 was changed
8/1/2010 - The description for Revenue code 0510 was changed
8/1/2010 - The description for Revenue code 0511 was changed
8/1/2010 - The description for Revenue code 0512 was changed
8/1/2010 - The description for Revenue code 0513 was changed
8/1/2010 - The description for Revenue code 0514 was changed
8/1/2010 - The description for Revenue code 0515 was changed
8/1/2010 - The description for Revenue code 0516 was changed
8/1/2010 - The description for Revenue code 0517 was changed
8/1/2010 - The description for Revenue code 0519 was changed
8/1/2010 - The description for Revenue code 0520 was changed
8/1/2010 - The description for Revenue code 0521 was changed
8/1/2010 - The description for Revenue code 0522 was changed
8/1/2010 - The description for Revenue code 0523 was changed
8/1/2010 - The description for Revenue code 0524 was changed
8/1/2010 - The description for Revenue code 0525 was changed
8/1/2010 - The description for Revenue code 0526 was changed
8/1/2010 - The description for Revenue code 0527 was changed
8/1/2010 - The description for Revenue code 0528 was changed
8/1/2010 - The description for Revenue code 0529 was changed
8/1/2010 - The description for Revenue code 0761 was changed
8/1/2010 - The description for Revenue code 0960 was changed
8/1/2010 - The description for Revenue code 0961 was changed
8/1/2010 - The description for Revenue code 0962 was changed
8/1/2010 - The description for Revenue code 0963 was changed
8/1/2010 - The description for Revenue code 0964 was changed
8/1/2010 - The description for Revenue code 0969 was changed

09/06/2010 - This policy was updated by the ICD-9 2010-2011 Annual Update.

11/21/2010 - For the following CPT/HCPCS codes either the short description and/or the long description was changed. Depending on which description is used in this LCD, there may not be any change in how the code displays in the document:

20552 descriptor was changed in Group 1
20553 descriptor was changed in Group 1
20526 descriptor was changed in Group 2
01966 descriptor was changed in Group 3
62318 descriptor was changed in Group 3
64479 descriptor was changed in Group 4
64480 descriptor was changed in Group 4
64483 descriptor was changed in Group 4
64484 descriptor was changed in Group 4
62318 descriptor was changed in Group 5
77003 descriptor was changed in Group 10

11/21/2011 - For the following CPT/HCPCS codes either the short description and/or the long description was changed. Depending on which description is used in this LCD, there may not be any change in how the code displays in the document:
62310 descriptor was changed in Group 3
62311 descriptor was changed in Group 3
62318 descriptor was changed in Group 3
62319 descriptor was changed in Group 3
64479 descriptor was changed in Group 4
64480 descriptor was changed in Group 4
64483 descriptor was changed in Group 4
64484 descriptor was changed in Group 4
62310 descriptor was changed in Group 5
62311 descriptor was changed in Group 5
62318 descriptor was changed in Group 5
62319 descriptor was changed in Group 5
27096 descriptor was changed in Group 8
77003 descriptor was changed in Group 10

11/21/2011 - The following CPT/HCPCS codes were deleted:
64622 was deleted from Group 7
64623 was deleted from Group 7
64626 was deleted from Group 7
64627 was deleted from Group 7

Reason for Change
HCPCS Addition/Deletion
Maintenance (annual review with new changes, formatting, etc.)

Related Documents
Article(s)
A48042 - Pain Management – Supplemental Instructions Article opens in new window

LCD Attachments
Pain Management opens in new window (a comment and response document) (PDF - 390 KB )

Updated on 05/04/2012 with effective dates 05/10/2012 - N/A
Updated on 12/21/2011 with effective dates 01/01/2012 - 05/09/2012
Updated on 12/16/2011 with effective dates 01/01/2012 - N/A
Local Coverage Article for Pain Management – Supplemental Instructions Article (A48042)

Contractor Name
National Government Services, Inc.

General Information

Article ID Number
A48042

Article Type
Article

Key Article
Yes

Article Title
Pain Management – Supplemental Instructions Article

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Original Article Effective Date
01/01/2009

Article Revision Effective Date
04/12/2012

Article Text
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 Guidelines:

General guidelines for claims submitted to carriers or intermediaries or Part A or Part B MAC:

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-9-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
Effective from April 1, 2010, non-covered services should be billed with modifier –GA, -GX, -GY, or –GZ, as appropriate.

The –GA modifier ("Waiver of Liability Statement Issued as Required by Payer Policy") should be used when physicians, practitioners, or suppliers want to indicate that they anticipate that Medicare will deny a specific service as not reasonable and necessary and they do have an ABN signed by the beneficiary on file. Modifier GA applies only when services will be denied under reasonable and necessary provisions, sections 1862(a)(1), 1862(a)(9), 1879(e), or 1879(g) of the Social Security Act. Effective April 1, 2010, Fiscal Intermediary (FI) and Part A MAC systems will automatically deny services billed with modifier GA. An ABN, Form CMS-R-131, should be signed by the beneficiary to indicate that he/she accepts responsibility for payment. The -GA modifier may also be used on assigned claims when a patient refuses to sign the ABN and the latter is properly witnessed. For claims submitted to the Fiscal Intermediary or Part A MAC, occurrence code 32 and the date of the ABN is required.

Modifier GX ("Notice of Liability Issued, Voluntary Under Payer Policy") should be used when the beneficiary has signed an ABN, and a denial is anticipated based on provisions other than medical necessity, such as statutory exclusions of coverage or technical issues. An ABN is not required for these denials, but if non-covered services are reported with modifier GX, FI and Part A MAC systems will automatically deny the services.

The –GZ modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an ABN signed by the beneficiary.

If the service is statutorily non-covered, or without a benefit category, submit the appropriate CPT/HCPCS code with the -GY modifier. An ABN is not required for these denials, and the limitation of liability does not apply for beneficiaries. Services with modifier GY will automatically deny.

**Specific coding guidelines for this policy:**

File CPT code 77003 when fluoroscopy is used or CPT code 77012 for CT guidance. An imaging guidance code is billed only once per session. Physicians may only bill for the professional component when imaging is performed in a hospital or non-office facility. No claim should be submitted for the hard or digital film(s) maintained to document needle placement.

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.

The CPT code 72275 (Epidurography, radiological supervision and interpretation) differs from CPT code 77003 in that it 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/nerve. 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-9-CM code V72.5 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.

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.

- 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.

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.

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.

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.

**ACUTE POST-OPERATIVE PAIN MANAGEMENT**

CPT codes 62310, 62311 should be used when the analgesia is delivered by a single injection.

These codes should only be used when the catheter or injection is not used for administration of anesthesia during the operative procedure. Modifier -59 should be used when billing these services to indicate that the catheter or injection was a separate procedure from the surgical anesthesia care.

In accordance with NCCI policy and edits, the epidural catheter insertion (CPT codes 62318 or 62319) includes the setup and start of the infusion. Therefore, the daily management of epidural or subarachnoid drug administration (CPT code 01996) should not be billed for the same day as the catheter insertion.

The time utilized for a single injection (CPT codes 62310 and 62311) or the insertion of the epidural catheter (CPT codes 62318 and 62319) should not be included in the time reported for the anesthesia care for the surgical procedure. The catheter insertion is considered a surgical procedure and should be coded with the number of services of one (1).

Do not code for the administration of any drug or other diagnostic substances used when inserting the catheter or performing the injection procedure.

The daily management of epidural or subarachnoid drug administration (CPT code 01996) is a daily service and should only be coded with a number of services (NOS) of one (1) for each day billed. Post-operative pain management services should be reported in the inpatient hospital setting (21) only.

**For claims submitted to the carrier or 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-9-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 fiscal intermediary or 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-9-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-9-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-9-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82).
- *The hospital enters the full ICD-9-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.

For dates of service prior to April 1, 2010, FQHC services should be reported with bill type 73X. For dates of service on or after April 1, 2010, bill type 77X should be used to report FQHC services.
**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.

- 011x Hospital Inpatient (Including Medicare Part A)
- 012x Hospital Inpatient (Medicare Part B only)
- 013x Hospital Outpatient
- 018x Hospital - Swing Beds
- 021x Skilled Nursing - Inpatient (Including Medicare Part A)
- 022x Skilled Nursing - Inpatient (Medicare Part B only)
- 023x Skilled Nursing - Outpatient
- 071x Clinic - Rural Health
- 073x Clinic - Freestanding
- 075x Clinic - Comprehensive Outpatient Rehabilitation Facility (CORF)
- 077x Clinic - Federally Qualified Health Center (FQHC)
- 085x Critical Access Hospital

**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 fiscal intermediary or Part A MAC Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or 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.

- 0360 Operating Room Services - General Classification
- 0450 Emergency Room - General Classification
- 049X Ambulatory Surgical Care - General Classification
- 050X Outpatient Services - General Classification
- 051X Clinic - General Classification
- 052X Free-Standing Clinic - General Classification
- 0761 Specialty Services - Treatment Room
CPT/HCPCS Codes

TRIGGER POINT INJECTIONS

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)

INJECTION OF TENDON SHEATHS, LIGAMENTS, GANGLION CYSTS, CARPAL AND TARSAL TUNNELS

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

EPIDURAL AND INTRATHECAL INJECTIONS - INTERLAMINAR AND CAUDAL

01996  DAILY HOSPITAL MANAGEMENT OF EPIDURAL OR SUBARACHNOID CONTINUOUS DRUG ADMINISTRATION 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

62310

62311

62318
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, ANTIISPASMODIC, OPIOID, STEROID, OTHER SOLUTION), NOT INCLUDING NEUROLYTIC SUBSTANCES, INCLUDES CONTRAST FOR LOCALIZATION WHEN PERFORMED, EPIDURAL OR SUBARACHNOID; LUMBAR OR SACRAL (CAUDAL)

EPIDURAL INJECTIONS – TRANSFORAMINAL

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

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

INJECTION, 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)

EPIDURAL AND INTRATHECAL INJECTIONS - ACUTE POST-OPERATIVE CARE MANAGEMENT

DAILY HOSPITAL MANAGEMENT OF EPIDURAL OR SUBARACHNOID CONTINUOUS DRUG ADMINISTRATION INJECTION(S), OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S) (INCLUDING ANESTHETIC, ANTIISPASMODIC, 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, ANTIISPASMODIC,
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)

PARAVERTEBRAL JOINT/NERVE BLOCKS – DIAGNOSTIC AND THERAPEUTIC

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
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; SECOND LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

64495
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)

PARAVERTEBRAL JOINT/NERVE DENERVATION

64633
DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE(S), WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); CERVICAL OR THORACIC, SINGLE FACET JOINT

64634
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)

64635
DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE(S), WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); LUMBAR OR SACRAL, SINGLE FACET JOINT

64636
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

SACROILIAC (SI) JOINT INJECTIONS

27096
INJECTION PROCEDURE FOR SACROILIAC JOINT, ANESTHETIC/STEROID, WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT) INCLUDING ARTHROGRAPHY WHEN PERFORMED

G0260
PROVISION OF ANESTHETIC, STEROID AND/OR OTHER THERAPEUTIC AGENT, WITH OR WITHOUT ARTHROGRAPHY
INTRATHECAL DRUGS

J0475  INJECTION, BACLOFEN, 10 MG
J0476  INJECTION, BACLOFEN, 50 MCG FOR INTRATHECAL TRIAL
J0735  INJECTION, CLONIDINE HYDROCHLORIDE, 1 MG
J1170  INJECTION, HYDROMORPHONE, UP TO 4 MG
J2275  INJECTION, MORPHINE SULFATE (PRESERVATIVE-FREE STERILE SOLUTION), PER 10 MG
J2278  INJECTION, ZICONOTIDE, 1 MICROGRAM
J3010  INJECTION, FENTANYL CITRATE, 0.1 MG
J3490  UNCLASSIFIED DRUGS

FLUOROSCOPIC GUIDANCE OR CT GUIDANCE

The following codes should be reported as indicated.

77003  FLUOROSCOPIC GUIDANCE AND LOCALIZATION OF NEEDLE OR CATHETER TIP FOR SPINE OR PARASPINOUS DIAGNOSTIC OR THERAPEUTIC INJECTION PROCEDURES (EPIDURAL OR SUBARACHNOID)

77012  COMPUTED TOMOGRAPHY GUIDANCE FOR NEEDLE PLACEMENT (EG, BIOPSY, ASPIRATION, INJECTION, LOCALIZATION DEVICE), RADIOLOGICAL SUPERVISION AND INTERPRETATION

ICD-9 Codes that are Covered
Please see LCD.

ICD-9 Codes that are Not Covered
Not applicable

Other Comments
These supplemental instructions apply within states outside the primary geographic jurisdiction with facilities that have nominated National Government Services to process their claims.

Revision History Explanation
Article published April 12, 2012: In the PARAVERTEBRAL JOINT/NERVE DENERVATION coding guidelines, a clarification has been made to indicate that CPT codes 64633, 64634, 64635 and 64636 are for each facet joint injected and not for each nerve injected.

Article published January 2012: CPT codes 64622, 64623, 64626, and 646427 were deleted from the coding Group for PARAVERTEBRAL JOINT/NERVE BLOCKS – DIAGNOSTIC AND THERAPEUTIC and PARAVERTEBRAL JOINT/NERVE DENERVATION and replaced with
CPT codes 64633, 64634, 64635, 64636 and throughout the policy. Descriptors were updated for 27096, 62310, 62311, 62318, 62319, 64479, 64480, 64483, 64484, and 77003. **Specific coding guidelines** for this policy were updated as follows: “File CPT code 77003 when fluoroscopy is used or CPT code 77012 for CT guidance. An imaging guidance code is billed only once per session. Physicians may only bill for the professional component when imaging is performed in a hospital or non-office facility. No claim should be submitted for the hard or digital film(s) maintained to document needle placement. 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.” **PARAVERTEBRAL JOINT/NERVE DENERVATION** coding guidelines were updated as follows: “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.” **SACROILIAC (SI) JOINT INJECTIONS** coding guidelines were updated as follows: “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 local coverage determination associated with this policy was similarly updated.

10/17/2011 - In accordance with Section 911 of the Medicare Modernization Act of 2003, intermediary numbers 00160 and 00332 are removed from this article. Effective on this date, claims processing for Kentucky – Part A and Ohio –Part A is performed by CGS Administrators, LLC, the Part A/Part B MAC contractor for these states.

05/16/2011 - In accordance with Section 911 of the Medicare Modernization Act of 2003, fiscal intermediary number 00453 is removed from this Article. Effective on this date, claims processing for Virginia and West Virginia is performed by Palmetto Government Benefits Administration, the Part A/Part B MAC contractor for these states.

04/30/2011 - In accordance with Section 911 of the Medicare Modernization Act of 2003, carrier number 00660 is removed from this Article. Effective on this date, claims processing for Kentucky is performed by Cigna Government Services, the Part A/Part B MAC contractor for this state.

**Article published January 2011:** HCPCS coding update for 2011. Descriptor changes were made to CPT codes 20552 and 20553 in Group 1, 20526 in Group 2, 62318 descriptor in Group 3, 64479, 64480, 64483, and 64484 in Group 4, 62318 in Group 5, and 77003 in Group 10. Coding guidelines for Epidural Injections - Transforaminal were updated as follows: "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." Minor changes were made to update for NGS template.

**Article published August 2010:** The CPT code list for EPIDURAL AND INTRATHECAL INJECTIONS - INTERLAMINAR AND CAUDAL; EPIDURAL INJECTIONS – TRANSFORAMINAL; ACUTE POST-OPERATIVE CARE MANAGEMENT was deleted and replaced with separate lists for EPIDURAL AND INTRATHECAL INJECTIONS - INTERLAMINAR AND CAUDAL; EPIDURAL INJECTIONS – TRANSFORAMINAL; EPIDURAL AND INTRATHECAL INJECTIONS - ACUTE POST-OPERATIVE CARE MANAGEMENT; and
INTRATHECAL DRUGS. No new CPT/HCPCS codes were added to the policy, and this does not represent a coding change. Other minor changes were made to update for current NGS and CMS template language and correct minor typographical errors. The LCD associated with this article was similarly updated.

Article published May 2010: The General Guidelines for claims submitted to Carriers or Intermediaries or Part A or Part B MAC section for TRIGGER POINT INJECTIONS AND INJECTIONS OF TENDON SHEATH, LIGAMENT, GANGLION CYST, CARPAL AND TARSAL TUNNELS were updated as follows: “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.” Limitation of liability guidelines revised in accordance with CMS Transmittals 1840 and 1921. The policy was reviewed and minor cosmetic changes were made to update for current NGS and CMS template language. TOB 83x was removed. The LCD associated with this policy was similarly updated.

Article published January 2010: CPT/HCPCS coding update 2010: CPT codes 64470, 64472 were deleted from group 4 (PARAVERTEBRAL JOINT/NERVE BLOCKS – DIAGNOSTIC AND THERAPEUTIC) and replaced with CPT codes 64490, 64491 and 64492. CPT codes 64475, 64476 were deleted from group 4 (PARAVERTEBRAL JOINT/NERVE BLOCKS – DIAGNOSTIC AND THERAPEUTIC) and replaced with CPT codes 64493, 64494 and 64495. The code descriptor was changed for CPT code 77003. The SIA was updated throughout to remove references to deleted codes and update for new codes.

General Guidelines for claims submitted to Carriers or Intermediaries or Part A or Part B MAC: were updated with the addition of the following: “Do not report CPT codes 64490–64495 unless fluoroscopic or CT guidance is performed.” and “For Paravertebral Spinal Nerves and Branches – Image guidance [fluoroscopy or CT] and any injection of contrast are inclusive components of 64490-64495.”

Coding instructions for Paravertebral Joint/Nerve Blocks – Diagnostic and Therapeutic were updated with the addition of the following: “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.”

Coding instructions 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 were updated with the addition of the following statement: CPT code G0260 may only be billed in the ambulatory surgery center (ASC) – POS 24. The –KX modifier instructions were updated as follows: “Ambulatory surgery centers 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 unless the image guidance is included in the description of the procedure code. 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.”
Based on CR 6338, Change Type of Bill (TOB) for Federally Qualified Health Centers (FQHCs) from 73x to 77x, the following paragraph has been added to the SIA: “For dates of service prior to April 1, 2010, FQHC services should be reported with bill type 73X. For dates of service on or after April 1, 2010, bill type 77X should be used to report FQHC services.” Minor changes were made to reflect current template language. The local coverage determination associated with this policy was similarly updated.

Article published May 2009:

The General Guidelines for claims submitted to Carriers or Intermediaries or Part A or Part B MAC were updated by adding the following:

Use ICD-9-CM code V72.5 only when procedure codes 62310, 62311, 62318, 62319 are used for injection of agents for diagnostic procedures unrelated to pain management (e.g., cisternography).

The Carrier Billing Guidelines under 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 were updated by adding the following:

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.

No change was made to the Local Coverage Determination associated with this Supplemental Instructions Article.

The changes listed in this latest version of the Supplemental Instructions Article (SIA) do NOT apply to the states of Maine (contract 00180), Massachusetts (contract 00181), or Vermont and New Hampshire (contract 00270); however, all other instructions, and requirements in the SIA remain in effect for these states.

Article published April 2009:

Place of service codes and instructions that had inadvertently been omitted were added to the section “For claims submitted to the carrier:” as follows:

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).

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.

**HCPCS DRUG CODES**

The medication being injected, designated by an appropriate HCPCS drug code should 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.

Policy was reorganized to update for current template changes and correction of minor typographical errors.

The changes listed in this latest version of the Supplemental Instructions Article (SIA) do NOT apply to the states of Maine (contract 00180), Massachusetts (contract 00181), or Vermont and New Hampshire (contract 00270); however, all other instructions, and requirements in the SIA remain in effect for these states.

**Article published January 2009**

05/15/2009 - In accordance with Section 911 of the Medicare Modernization Act of 2003, fiscal intermediary numbers 00180 and 00181 were removed from this Article as the claims processing for Maine and Massachusetts was transitioned to NHIC, the Part A/Part B MAC contractor in these states.

06/05/2009 - In accordance with Section 911 of the Medicare Modernization Act of 2003, fiscal intermediary number 00270 was removed from this article as the claims processing for New Hampshire and Vermont was transitioned to NHIC, the Part A/Part B MAC contractor in these states.

8/10/2009 - The description for Revenue code 0761 was changed
11/15/2009 - The description for CPT/HCPCS code 77003 was changed in group 7
11/15/2009 - CPT/HCPCS code 64470 was deleted from group 4
11/15/2009 - CPT/HCPCS code 64472 was deleted from group 4
11/15/2009 - CPT/HCPCS code 64475 was deleted from group 4
11/15/2009 - CPT/HCPCS code 64476 was deleted from group 4

3/7/2010 - The description for Bill Type Code 73 was changed
3/7/2010 - The description for Bill Type Code 77 was changed

8/1/2010 - The description for Bill Type Code 11 was changed
8/1/2010 - The description for Bill Type Code 12 was changed
8/1/2010 - The description for Bill Type Code 13 was changed
8/1/2010 - The description for Bill Type Code 18 was changed
8/1/2010 - The description for Bill Type Code 21 was changed
8/1/2010 - The description for Bill Type Code 22 was changed
8/1/2010 - The description for Bill Type Code 23 was changed
8/1/2010 - The description for Bill Type Code 71 was changed
8/1/2010 - The description for Bill Type Code 73 was changed
8/1/2010 - The description for Bill Type Code 75 was changed
8/1/2010 - The description for Bill Type Code 85 was changed

8/1/2010 - The description for Revenue code 0360 was changed
8/1/2010 - The description for Revenue code 0450 was changed
8/1/2010 - The description for Revenue code 0490 was changed
8/1/2010 - The description for Revenue code 0499 was changed
8/1/2010 - The description for Revenue code 0500 was changed
8/1/2010 - The description for Revenue code 0509 was changed
8/1/2010 - The description for Revenue code 0510 was changed
8/1/2010 - The description for Revenue code 0511 was changed
8/1/2010 - The description for Revenue code 0512 was changed
8/1/2010 - The description for Revenue code 0513 was changed
8/1/2010 - The description for Revenue code 0514 was changed
8/1/2010 - The description for Revenue code 0515 was changed
8/1/2010 - The description for Revenue code 0516 was changed
8/1/2010 - The description for Revenue code 0517 was changed
8/1/2010 - The description for Revenue code 0519 was changed
8/1/2010 - The description for Revenue code 0520 was changed
8/1/2010 - The description for Revenue code 0521 was changed
8/1/2010 - The description for Revenue code 0522 was changed
8/1/2010 - The description for Revenue code 0523 was changed
8/1/2010 - The description for Revenue code 0524 was changed
8/1/2010 - The description for Revenue code 0525 was changed
8/1/2010 - The description for Revenue code 0526 was changed
8/1/2010 - The description for Revenue code 0527 was changed
8/1/2010 - The description for Revenue code 0528 was changed
8/1/2010 - The description for Revenue code 0529 was changed
8/1/2010 - The description for Revenue code 0761 was changed
8/1/2010 - The description for Revenue code 0960 was changed
8/1/2010 - The description for Revenue code 0961 was changed
8/1/2010 - The description for Revenue code 0962 was changed
8/1/2010 - The description for Revenue code 0963 was changed
8/1/2010 - The description for Revenue code 0964 was changed
8/1/2010 - The description for Revenue code 0969 was changed
11/21/2010 - For the following CPT/HCPCS codes either the short description and/or the long description was changed. Depending on which description is used in this article, there may not be any change in how the code displays in the document:
20552 descriptor was changed in Group 1
20553 descriptor was changed in Group 1
20526 descriptor was changed in Group 2
62318 descriptor was changed in Group 3
64479 descriptor was changed in Group 4
64480 descriptor was changed in Group 4
64483 descriptor was changed in Group 4
64484 descriptor was changed in Group 4
62318 descriptor was changed in Group 5
77003 descriptor was changed in Group 10

11/21/2011 - For the following CPT/HCPCS codes either the short description and/or the long description was changed. Depending on which description is used in this article, there may not be any change in how the code displays in the document:
62310 descriptor was changed in Group 3
62311 descriptor was changed in Group 3
62318 descriptor was changed in Group 3
62319 descriptor was changed in Group 3
64479 descriptor was changed in Group 4
64480 descriptor was changed in Group 4
64483 descriptor was changed in Group 4
64484 descriptor was changed in Group 4
62310 descriptor was changed in Group 5
62311 descriptor was changed in Group 5
62318 descriptor was changed in Group 5
62319 descriptor was changed in Group 5
27096 descriptor was changed in Group 8
77003 descriptor was changed in Group 10

11/21/2011 - The following CPT/HCPCS codes were deleted:
64622 was deleted from Group 7
64623 was deleted from Group 7
64626 was deleted from Group 7
64627 was deleted from Group 7

Related Document(s)
LCD(s)
L28529 - Pain Management opens in new window
Updated on 12/23/2010 with effective dates 01/01/2011 - N/A
Updated on 11/21/2010 with effective dates 08/01/2010 - N/A
Updated on 08/01/2010 with effective dates 08/01/2010 - N/A
Updated on 08/01/2010 with effective dates 08/01/2010 - N/A
Updated on 07/20/2010 with effective dates 08/01/2010 - N/A
Updated on 04/22/2010 with effective dates 05/01/2010 - N/A
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