FUTURE DRAFT Local Coverage Determination (LCD) for Surgery: Injections of the Spinal Canal (DL32112)

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Please note: This is a Draft policy.
Draft LCDs are works in progress that are available on the Medicare Coverage Database site for public review. Draft LCDs are not necessarily a reflection of the current policies or practices of the contractor.

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Please note: This is a Future Draft LCD.

Contractor Information

Contractor Name	Contractor Number	Contractor Type
Cahaba Government Benefit Administrators®, LLC	10202	MAC - Part B

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LCD Information

Document Information

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LCD ID Number
DL32112

LCD Title
Surgery: Injections of the Spinal Canal

Contractor's Determination Number

AMA CPT/ADA CDT Copyright Statement

Primary Geographic Jurisdiction
Georgia

Oversight Region
Region IV

Original Determination Effective Date
For services performed on or after 01/01/2012

Original Determination Ending Date

Revision Effective Date
For services performed on or after 01/01/2012

Revision Ending Date

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CMS National Coverage Policy

- Title XVIII of the Social Security Act, Section 1833 (e). This section states that no payment shall be made to any provider for any claims that lack the necessary information to process the claim.
- Title XVIII of the Social Security Act, Section 1862(a)(1)(A). This section allows coverage and payment for only those services that are considered to be reasonable and medically necessary, i.e., reasonable and necessary are those tests used in the diagnosis and management of illness or injury or to improve the function of a malformed body part.
- Medicare Program Integrity Manual (Pub. 100-08), Chapter 13, Local Coverage Determinations.

Indications and Limitations of Coverage and/or Medical Necessity
Indications

These procedures are used to inject a substance into the subarachnoid, subdural or epidural space for the relief of pain or spasticity. The following list of examples is not all inclusive of the indications for injections of the spinal canal.

1. Intervertebral disc disease (with neuritis, radiculitis, sciatica) with or without myelopathy;
2. Complex regional pain syndrome;
3. Post herpetic neuralgia;
4. Traumatic neuropathy of the spinal nerve roots;
5. Postlaminectomy syndrome (failed back syndrome);
6. Chronic severe pain due to carcinoma;
7. Acute and chronic postoperative pain;
8. Chronic upper and lower extremity radicular symptoms (i.e. spinal stenosis).

Prior to any interventional pain procedure and regardless of the longevity of pain (i.e. acute, subacute, chronic, etc.), a patient must have failed to respond to conservative management. Examples of conservative management include physical therapy modalities, chiropractic manipulation, and medication management. The fact that a patient has chronic pain does not preclude the option of a retrial of conservative management at some point during their care. Although conservative management should be attempted, this requirement may be waived for the infrequent patient who is unable to tolerate it.

Limitations

1. An injection session is defined as all injection services of the spinal canal administered during a 24 hour period for a specific date of service per region (cervical, thoracic or lumbosacral). Therefore,

   A. In the first year, up to six (6) injection sessions per region may be performed: up to two (2) diagnostic and up to four (4) therapeutic.
   B. In the following years, up to four (4) therapeutic injection sessions per region may be performed.

2. There is limited peer-reviewed medical literature substantiating the use of alcohol, phenol, or iced saline solutions for either subarachnoid or epidural pain relief (CPT codes 62280, 62281, 62282). Use of these codes requires specific narrative documentation supporting the use of either alcohol, phenol, or iced saline solutions.

3. The use of fluoroscopic or computed tomographic (CT) guidance is required when performing injections of the spinal canal. Transforaminal epidural injections with ultrasound guidance (CPT codes 0228T - 0231T) will be denied as investigational.

4. Performance of more than one type of injection for pain treatment, such as epidural, sacroiliac joint injections or lumbar sympathetic injections, on the same day as a diagnostic spinal injection is not considered reasonable and necessary.

5. Clinicians performing these services must have appropriate training in interventional pain management and radiographic guidance. Documentation of this training must be maintained at the site of practice.

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Coding Information

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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.

999x	Not Applicable

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.

99999	Not Applicable

CPT/HCPCS Codes
GroupName

62280	INJECTION/INFUSION OF NEUROLYTIC SUBSTANCE (EG, ALCOHOL, PHENOL, ICED SALINE SOLUTIONS), WITH OR WITHOUT OTHER THERAPEUTIC SUBSTANCE; SUBARACHNOID
62281	INJECTION/INFUSION OF NEUROLYTIC SUBSTANCE (EG, ALCOHOL, PHENOL, ICED SALINE SOLUTIONS), WITH OR WITHOUT OTHER THERAPEUTIC SUBSTANCE; EPIDURAL, CERVICAL OR THORACIC
62282	INJECTION/INFUSION OF NEUROLYTIC SUBSTANCE (EG, ALCOHOL, PHENOL, ICED SALINE SOLUTIONS), WITH OR WITHOUT OTHER THERAPEUTIC SUBSTANCE; EPIDURAL, LUMBAR, SACRAL (CAUDAL)
62310	

	INJECTION, SINGLE (NOT VIA INDWELLING CATHETER), NOT INCLUDING NEUROLYTIC SUBSTANCES, WITH OR WITHOUT CONTRAST (FOR EITHER LOCALIZATION OR EPIDUROGRAPHY), OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S) (INCLUDING ANESTHETIC, ANTISPASMODIC, OPIOID, STEROID, OTHER SOLUTION), EPIDURAL OR SUBARACHNOID; CERVICAL OR THORACIC
62311	INJECTION, SINGLE (NOT VIA INDWELLING CATHETER), NOT INCLUDING NEUROLYTIC SUBSTANCES, WITH OR WITHOUT CONTRAST (FOR EITHER LOCALIZATION OR EPIDUROGRAPHY), OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S) (INCLUDING ANESTHETIC, ANTISPASMODIC, OPIOID, STEROID, OTHER SOLUTION), EPIDURAL OR SUBARACHNOID; LUMBAR, SACRAL (CAUDAL)
64479	INJECTION(S), ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); CERVICAL OR THORACIC, SINGLE LEVEL
64480	INJECTION(S), ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); CERVICAL OR THORACIC, EACH ADDITIONAL LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
64483	INJECTION(S), ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); LUMBAR OR SACRAL, SINGLE LEVEL
64484	INJECTION(S), ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); LUMBAR OR SACRAL, EACH ADDITIONAL LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

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The CPT codes listed below will be denied as investigational:

0228T - 0231T	INJECTION(S), ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH ULTRASOUND GUIDANCE, CERVICAL OR THORACIC; SINGLE LEVEL - INJECTION(S), ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH ULTRASOUND GUIDANCE, LUMBAR OR SACRAL; EACH ADDITIONAL LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0229T	INJECTION(S), ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH ULTRASOUND GUIDANCE, CERVICAL OR THORACIC; EACH ADDITIONAL LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0230T	INJECTION(S), ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH ULTRASOUND GUIDANCE, LUMBAR OR SACRAL; SINGLE LEVEL
0231T	INJECTION(S), ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH ULTRASOUND GUIDANCE, LUMBAR OR SACRAL; EACH ADDITIONAL LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

ICD-9 Codes that Support Medical Necessity

There are numerous reasonable and necessary conditions that might warrant the use of these procedures but which are too many to list. However, an appropriate ICD-9-CM diagnosis must be submitted with each claim and failure to do so may result in denial or delay in claim processing.

ICD-9 codes must be coded to the highest level of specificity. Consult the 'Official ICD-9-CM Guidelines for Coding and Reporting' in the current ICD-9-CM book for correct coding guidelines. This LCD does not take precedence over the Correct Coding Initiative (CCI).

XX000*	Not Applicable

N/A

Diagnoses that Support Medical Necessity

N/A

ICD-9 Codes that DO NOT Support Medical Necessity

See narrative above for "ICD-9 Codes that Support Medical Necessity".

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

Diagnoses that DO NOT Support Medical Necessity
N/A
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General Information

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Documentations Requirements
In general, documentation includes an initial evaluation, a periodic re-evaluation, and a procedure note. The following outlines the minimum documentation expectations and should reflect the 'Indication' requirements.

1. Initial Evaluation

   A. History:
      i. A detailed clinical pain history (e.g., applicable injuries, history of pain, pain levels, co-morbid conditions, etc.)
      ii. If applicable, history of prior procedural interventions (e.g., spinal surgeries, spinal blocks, etc.)
      iii. Poor or inadequate response to, or inability to tolerate, conservative management as outlined in 'Indications'

   B. Findings of imaging studies

   C. Physical Exam:
      - Functional impairment (This should include the baseline information from which 'improvement from the spinal injection' is based.)

   D. Treatment Plan:
      i. Details of intervention to be performed (e.g., levels, left/right, etc.)
      ii. Any other pain management (e.g. physical therapy, medication management, etc.) to start or continue
      iii. Additional imaging, if applicable

2. Periodic Re-evaluation

   There are no proscriptive requirements for the frequency of a re-evaluation; re-evaluation of a patient who receives ongoing spinal injections should occur at least every 12 - 18 months. The re-evaluation should:

   A. Summarize the patient's history

   B. Review interventions performed to date

   C. Review and assess responses to date (i.e., functional improvements from baseline, decreased pain scores, etc.)

   D. Outline rationale for ongoing interventions or other pain managements

3. Procedure Note

A. History: A brief overview of the patient's pathology and responses to previous interventions, when applicable

B. Diagnostic versus therapeutic

C. Procedure details

D. Radiographic guidance (specify fluoroscopic or CT)

E. Patient's 'post procedure' response (e.g., pre and post pain scores, etc.)

4. All 'Indications' must be clearly documented in the patient's medical record and made available to Medicare upon request.

5. The most recent Evaluation (i.e., Initial Evaluation or Re-evaluation) should be submitted as part of any review documentation request.

6. Documentation must support CMS 'signature requirements' as described in the Medicare Program Integrity Manual (Pub. 100-08), Chapter 3.

Appendices N/A

Utilization Guidelines

1. An injection session is defined as all injection services of the spinal canal administered during a 24 hour period for a specific date of service per region (cervical, thoracic or lumbosacral). Therefore,

   A. In the first year, up to six (6) injection sessions per region may be performed: up to two (2) diagnostic and up to four (4) therapeutic.
   B. In the following years, up to four (4) therapeutic injection sessions per region may be performed.

2. A therapeutic epidural injection may be repeated only if there was a positive response to the previous procedure, involving either an analgesic or functional benefit to the patient. If there was no improvement in pain, examination findings, or function (in terms of activity level or tolerance) then the previous procedure should not be repeated.

3. Services exceeding the above utilization parameter may be subject to medical review or auto-adjudication.

Sources of Information and Basis for Decision

- American Society of Anesthesiologists Task Force on Chronic Pain Management, American Society of Regional Anesthesia and Pain Medicine. Practice Guidelines for Chronic Pain Management; An Updated Report by the American Society of Anesthesiologists Task Force on Chronic Pain Management and the American Society of Regional Anesthesia and Pain Medicine. *Anesthesiology*. 2010: April; 112(4): 810-33.
- Boswell, Mark V., MD, et al. Interventional Techniques: Evidence based Practice Guidelines in the Management of Chronic Spinal Pain. *Pain Physician*: January 2007: 10: 7-111.
- Consultations with the representatives to the Carrier Advisory Committee and other Medicare contractors.
- Manchikanti L, MD et al. Comprehensive evidence-based guidelines for interventional techniques in the management of chronic spinal pain. *Pain Physician*. 2009: Jul-Aug; 12(4):699-802.

- Manchikanti L, MD et al. Comprehensive Review of Therapeutic Interventions in Managing Chronic Spinal Pain. *Pain Physician*. 2009; Jul-Aug; 12: E123-E198.
- Other Medicare Contractor's Local Coverage Determinations.

Advisory Committee Meeting Notes **Date of Open Meeting:**

07/12/2011

Dates of Carrier Advisory Committee (CAC) Meetings:

07/12/2011 (Alabama)
07/14/2011 (Tennessee)
07/22/2011 (Georgia)

This local coverage determination (LCD) does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the contractor, this LCD was developed in cooperation with advisory groups, which include representatives from physician specialties; representatives from the Medical Associations for the above states; and other Association Representatives.

Start Date of Comment Period 07/11/2011

End Date of Comment Period 08/26/2011

Start Date of Notice Period 11/15/2011

Revision History Number

Revision History Explanation **What's New Posted Date: November 2011**
Newsline Published Date: November 2011
Effective Date: January 1, 2012
Notice Period: November 15, 2011 – December 31, 2011

This LCD has been finalized and will become effective January 1, 2012.

Reason for Change

Related Documents
Article(s)
A51461 - LCD - MAC - Comment - Surgery: Injections of the Spinal Canal

LCD Attachments
There are no attachments for this LCD.

Draft Contact

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All Versions

Updated on 11/02/2011 with effective dates 01/01/2012 - N/A
Updated on 11/02/2011 with effective dates 01/01/2012 - N/A
Updated on 06/17/2011 with effective dates N/A
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