Washington State Department of Labor & Industries

OCCUPATIONAL HEALTH **BEST PRACTICES**

WORKING TOGETHER TO KEEP PEOPLE WORKING

Spinal Injections Coverage Decision

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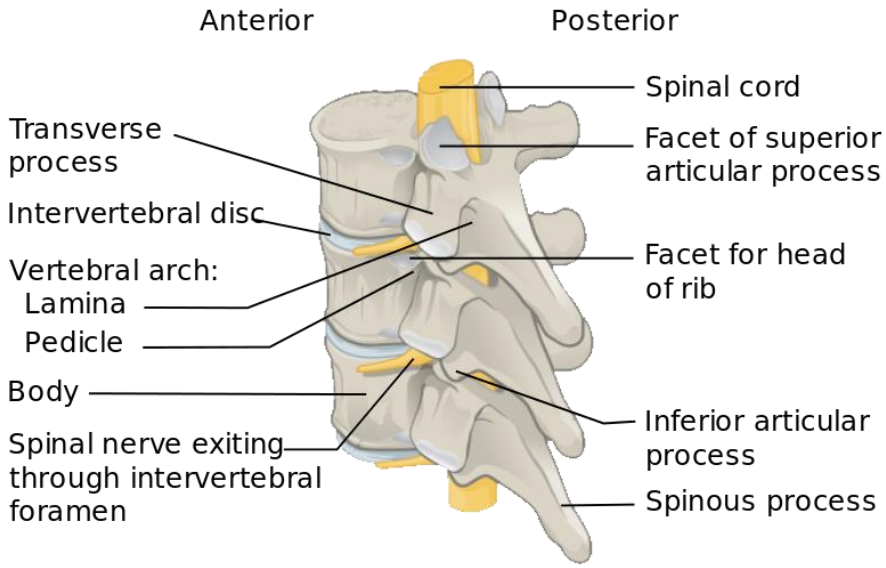
ESI language corrected September 2018; Hyperlinks to evidence resources added May 2018.
Minor formatting updates June 2023

Introduction

There are different kinds of spinal injections, each with a different purpose, risk level, and degree of effectiveness. Spinal injections can provide pain relief and functional improvement for up to several months, but their effects are not permanent. They involve the injection of a steroid and/or anesthetic into the spine or space around the spinal nerves and joints. This coverage decision describes the purpose of each type of injection and addresses the criteria required for authorization. The criteria for allowing these injections are based on L&I's Medical Aid Rules (WACs) and decisions of the statutory Health Technology Clinical Committee (HTCC). Decisions of the HTCC are mandatory for state agencies. Hyperlinks to the basis for these decisions are in a coverage table at the end of this policy. This summary is consistent with the most recent HTCC decision of May 20, 2016.



By Jmarchn (Own work) [CC BY-SA 3.0 (http://creativecommons.org/licenses/by-sa/3.0)], via Wikimedia Commons; https://commons.wikimedia.org/wiki/File%3AVertebra_Posterolateral-en.svg

Medial Branch Blocks

Diagnostic

Medial branch blocks are ONLY allowed as part of a diagnostic workup for a possible facet neurotomy (destruction of the nerve). The theory is that by destroying specific nerve(s) along the spine, pain signals to the brain mediated by the nerve(s) are interrupted. A diagnostic medial branch block is used to identify which nerve(s), if destroyed, could relieve the pain. Refer to the facet neurotomy guideline before planning a medial branch block.

Therapeutic

Therapeutic medial branch blocks are not covered because they are not effective in relieving pain. **Note:** CPT codes are the same for medial branch block injections regardless of their purpose; however, only diagnostic medial branch blocks are covered.

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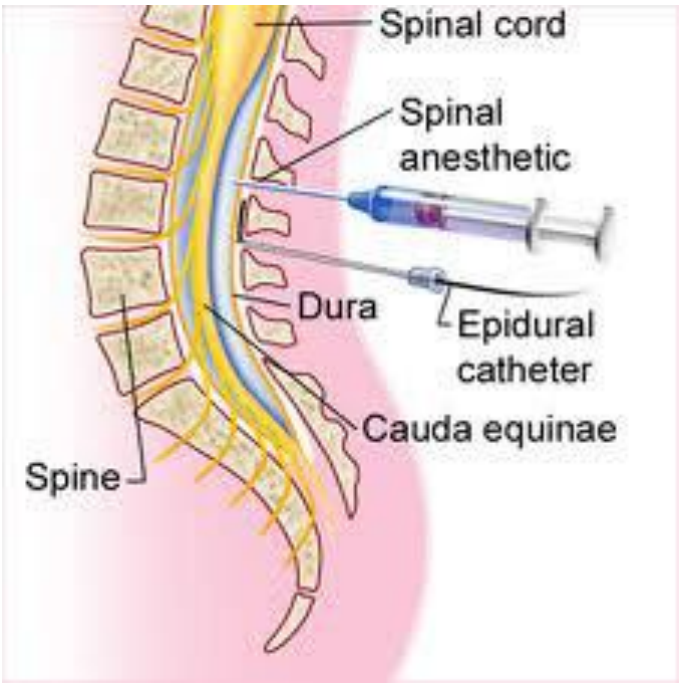
Facet Injections

Injections directly into the facet joint are ineffective at relieving pain and have no role in diagnosing conditions; hence, **both therapeutic and diagnostic facet injections are not covered**.

Epidural Injections

With epidural injections, substances are injected within the spine but outside the spinal canal. Depending on what is injected, they can be done as part of a diagnostic imaging procedure (using contrast medium), or therapeutically for either anesthesia (using an anesthetic) or pain management (using a steroid and anesthetic).



Graphic by Professional Pain Management Associates, New Jersey

Epidural injections are covered when all the following criteria are met:

1. The injured worker has a spine condition that has been allowed on the claim.
2. The injured worker's level of pain and function are clearly documented on a validated Scale at baseline prior to treatment and no more than 2 weeks before the injection.
3. Fluoroscopic or CT guidance is used
4. Radicular pain **or** radiculopathy is present and related to the allowed condition as defined below:
    a. Radicular pain: pain radiating down the leg or arm. If only radicular pain is present, (with or without positive straight leg raise testing), there must be a failure of at least 4 weeks of conservative therapy.
    b. Radiculopathy: radicular pain with documented objective findings and failure of at least 2 weeks of conservative therapy. Objective findings may include:

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i. Motor weakness
ii. Dermatomal sensory loss
iii. Reflex asymmetry or loss
iv. A positive diagnostic selective nerve root block is done that is: single-level, low-volume, steroid-free, and includes a post-block pain diary and possible placebo injection in the series

Selective Nerve Root Blocks (SNRBs)

SNRBs may be used when a worker has had 6 weeks of conservative care and still has radicular pain with positive imaging findings, but does not have the objective signs of motor, reflex or EMG changes. Use SNRBs only when:

- The worker has clear sensory symptoms indicative of radiculopathy or nerve root irritation, and
- The worker's symptoms and exam findings are consistent with injury or irritation of the nerve root that is to be blocked; and
- Injury or irritation of the nerve root to be blocked has not been identified by electrodiagnostic, imaging or other studies.

Steroids should not be used for SNRBs. Selective nerve root blocks with steroids do not meet criteria for surgery. For cervical SNRBs, refer to Diagnosis and Treatment of Cervical Radiculopathy and Myelopathy Guideline for appropriate criteria.

Epidural Steroid Injections

When steroids are used in epidural injections, the following limitations apply*:

1. Bilateral ESIs are not allowed.
2. No more than 2 levels on one side per date of service are allowed.
3. No more than 2 ESIs on 2 different dates can be given without clinically meaningful improvement of pain and function of at least 30%, compared to the baseline pain and function prior to the first ESI. All changes should be measured and documented using a validated Scale. If there is no such improvement, no further ESIs should be allowed.
4. No more than 3 ESIs within 6 months with at least 6 weeks between each ESI are allowed. Again, clinically meaningful improvement of pain and function of at least 30%, as measured and documented by a validated scale, must be shown for subsequent ESIs to be allowed.
5. No more than 4 ESIs within a 365-day period with at least 6 weeks between them *unless* there is a documented improvement of pain and function of at least 50% from baseline, as measured by a validated scale, AND at least one of the following is present:
    a. Sustained, progressive improvement in strength, stamina or agility
    b. Sustained participation in work-hardening or work conditioning programs
    c. Sustained participation in the retraining phase of vocational rehabilitation process
    d. The worker has returned to work

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* For therapeutic ESIs, these limitations do not apply when there is a known systemic inflammatory disease such as: ankylosing spondylitis, psoriatic arthritis or enteropathic arthritis.

MRI's are not a prerequisite for ESIs.

Caudal Injections

Caudal injections are the same as epidurals only the location (tip of the sacrum/tailbone) and approach are different. **Therapeutic caudal injections are subject to the criteria for epidural injections**.

Subarachnoid (Intrathecal) Injections

Subarachnoid injections penetrate the dura/lining that surrounds the spinal canal and may only be done with contrast medium for diagnostic imaging or with anesthetic for therapeutic treatment of chronic pain. **Injections of substances other than contrast or anesthetic are not covered.**

To minimize the risk of the serious complications that can follow the insertion of a needle and the injection of substances into the subarachnoid space, careful consideration should be given to determining whether an MRI scan can substitute for a study requiring the injection of contrast into the subarachnoid space.

Sacroiliac Joint Injections

Therapeutic or diagnostic sacroiliac joint injections are covered services when all the following criteria are met:

1. Patient has an allowed condition that includes sacroiliac joint pain.
2. Failure of at least 6 weeks of conservative therapy.
3. Fluoroscopic or CT guidance is used.
4. No more than one injection without clinically meaningful improvement, as documented by a validated scale. Additional injections require clinical review.

* For therapeutic sacroiliac injections, this coverage decision does not apply to those with a known systemic inflammatory disease such as ankylosing spondylitis, psoriatic arthritis or enteropathic arthritis.

Intradiscal Injections

Therapeutic intradiscal injections are not covered services. Diagnostic intradiscal injections such as discography are not covered for the assessment of chronic low back pain or lumbar degenerative disc disease (see coverage decision on discography).

Clinically Meaningful Improvement

Patients experiencing clinically meaningful improvement in pain and function as measured and documented on a validated instrument should exhibit:

1) A significant reduction in pain of at least 30% produced by the most recent injection compared to the pre-injection pain level.

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2) A significant improvement in function of at least 30% produced by the most recent injection compared to the pre-injection function level. Such improvement in function can be observed in many different ways, and will likely vary patient to patient such as:
   a) Sustained progressive improvement in strength, stamina or agility
   b) Sustained participation in work-hardening or work conditioning programs
   c) Sustained participation in the vocational rehabilitation process.

While there is no universally accepted tool to assess a worker's pain and function, the Washington State Agency Medical Directors' Group (AMDG), in its opioid dosing guideline, recommends the use of the Two Item Graded Chronic Pain Scale. This is a quick, two-question tool to track both pain and function when administered regularly. Other functional assessment tools that are validated and disease-specific may also be used. If a disease-specific tool is used, each tool will have its own definition for clinically meaningful improvement.

Two Item Graded Chronic Pain Scale

Graded chronic pain scale: a two-item tool to assess pain intensity and pain interference

In the last month, on average, how would you rate your pain? [*That is, your usual pain at times you were in pain.*]

No pain										**Pain as bad as could be**
0	1	2	3	4	5	6	7	8	9	10

In the last month, how much has pain interfered with your daily activities?

No interference										**Unable to carry on any activities**
0	1	2	3	4	5	6	7	8	9	10

Interpretation of the Two Item Graded Chronic Pain Scale – This two-item version of the Graded Chronic Pain Scale is intended for brief and simple assessment of pain severity in primary care settings. Based on prior research, the interpretation of scores on these items is as follows:

Pain Rating Item	Mild	Moderate	Severe
Average/Usual Pain Intensity	1–4	5–6	7–10
Pain-related interference with activities	1–3	4–6	7–10

Although pain intensity and pain-related interference with activities are highly correlated and tend to change together, it is recommended that change over time be tracked for pain intensity and pain-related interference with activities separately when using these two items. For an individual patient, a reduction in pain intensity and improvement in pain-related interference with activities of two points is considered moderate but clinically significant improvement.

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Definition of conservative therapy: Conservative therapy includes evidence-based treatments such as physical therapy or graded exercise, massage, and medications that have been demonstrated to be of use in the management of low back or neck pain.
For a reference on conservative treatment of low back pain, see:

Chou R, Quaseem A, Snow V, Casey D, Cross TJ, Shekelle P and Owens DK. Diagnosis and Treatment of Low Back Pain: A Joint Clinical Guideline from the American College of Physicians and the American Pain Society. Annals of Internal Medicine 2007; 147:478-491.

Coverage Table

Therapeutic	HTA	WAC	L&I Coverage Decision
Medial Branch Block	Not covered	WAC 296-20-03002	Not covered
Facet injections	Not covered	WAC 296-20-03002	Not covered
Epidural	Covered with conditions	Requires authorization for chronic pain WAC 296-20-03001	Covered with conditions
Caudal (type of epidural)	Not mentioned	Requires authorization for chronic pain WAC 296-20-03001	Covered with conditions
Subarachnoid (intrathecal)	Not mentioned	WAC 296-20-03001 requires prior authorization for chronic pain; WAC 296-20-03002 allows only for contrast and anesthetic and requires prior authorization	Covered with conditions
Sacroiliac joint	Covered with conditions	WAC 296-20-03001 requires prior authorization for chronic pain	Covered with conditions
Intradiscal	Not covered	WAC 296-20-03002	Not covered
Diagnostic			
Medial Branch Block	Covered with conditions	Not mentioned	Covered with conditions
Facet injection	Not mentioned	WAC 296-20-03001	Not covered
Epidural	Not mentioned	Not mentioned	Covered with conditions
Caudal (type of epidural)	Not mentioned	Not mentioned	Covered with conditions
Subarachnoid (intrathecal)	Not mentioned	WAC 296-20-03002 allows contrast and anesthetic only	Covered with conditions

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Sacroiliac joint	Not mentioned	Not mentioned	Covered with conditions
Intradiscal	Covered except for chronic low back pain and lumbar DDD	Not mentioned	Covered except for chronic low back pain and lumbar DDD

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Prior authorization

All requests for spinal injections require prior authorization.

For L&I Claims

Authorizations go through L&I's utilization review (UR) vendor, Comagine Health. You may contact Comagine Health in any of the following ways:

Web: As of January 1, 2017, Comagine Health requires spinal injection UR requests to be submitted via a secure, on-line application through OneHealthPort's Single Sign-On site.

Phone: 800-541-2894 (toll free) or 206-366-3360
Fax: 877-665-0383 (toll free) or 206-366-3378
Email: WaGovtProviders@qualishealth.org

For Crime Victims

Authorizations can be directed to the Crime Victims' Compensation Program's Claim Manager.
Phone: 800-762-3716 (toll free)
Fax: 360-902-5333

For Self-Insured Claims

Contact the self-insured employer (SIE) or their third party administrator (TPA) to request authorization. L&I's website has a list of SIE/TPAs.

Billing

Billing information can be found in the Payment Policies section of L&I's fee schedule.

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