Local Coverage Determination (LCD) for Pain Management (L31845)

Contractor Information

Contractor Name	Contractor Number	Contractor Type
CGS Administrators, LLC	15201	MAC - Part A

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LCD Information

Document Information

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Pain Management

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AMA CPT/ADA CDT Copyright Statement

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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).

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 Determination Manual*, Chapter 1:

30.3 Acupuncture
150.7 Prolotherapy, Joint Sclerotherapy, and Ligamentous Injections with Sclerosing Agents
160.1 Induced Lesions of Nerve Tracts
220.1 Computerized Tomography
280.14 Infusion Pumps

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12:

40 Surgeons and Global Surgery
70 Payment Conditions for Radiology Services
50 Payment for Anesthesiology Services
140.3.2 Anesthesia Time and Calculation of Anesthesia Time Units

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 13:

10 ICD -9-CM Coding for Diagnostic Tests
20 Payment Conditions for Radiology Services
30 Computerized Axial Tomography (CT) Procedures

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 23:

20.9 Correct Coding Initiative (CCI)

CMS Publication 100-08, *Program Integrity Manual*, Chapter 13

13.5.1 – Reasonable and Necessary Provisions in LCDs

CMS Transmittal No. 526, Publication 100-20, One-Time Notification, Change Request #6518, July 31, 2009, updates requirements for the “Appropriate Use of Modifier 50 and Add-On Codes for Facet Joint Injections Services.”

National Correct Coding Initiative Policy Manual for Medicare Services, Chapter II: Anesthesia Services. CPT Codes 00000-09999.

Indications and Limitations of Coverage and/or Medical Necessity
Abstract:

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

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

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

Spinal pain generates from multiple structures in the spine. Certain conditions may not be detectable using currently available technology or biochemical studies. However, for a structure to be implicated, it should have been shown to be a source of pain in patients, using diagnostic techniques of known reliability and validity. The structures responsible for pain in the spine, include but are not limited to, the vertebral bodies, intervertebral discs, spinal cord, nerve roots, facet joints, ligaments, muscles, atlanto-occipital joints, atlanto-axial joints, and sacroiliac joints.

Postlaminectomy syndrome or pain following operative procedures of the spine, sometimes known as failed management syndrome, is becoming an increasingly common entity in modern medicine. Other spinal conditions causing pain include various degenerative disorders such as spinal stenosis, spondylolysis, spondylolisthesis, degenerative scoliosis, idiopathic vertebrogenic sclerosis, diffuse idiopathic spinal hyperostosis, and segmental instability. Degenerative conditions other than disc disruption and facet arthritis may contribute to approximately 5% to 10% of spinal pain.

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

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

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 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). Steroid can be added as a therapeutic measure. Injections for therapeutic reasons can be of greater volume. The block can be performed for diagnostic, therapeutic, or both purposes.

Transforaminal epidural injections are appropriate for the following **diagnostic** purposes:

- To differentiate the level of radicular nerve root pain;
- To differentiate radicular from non-radicular pain;
- To evaluate a discrepancy between imaging studies and clinical findings;
- To identify the source of pain in the presence of multi-level nerve root compression; and/or
- To identify the level of pathology at a previous operative site.

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

Transforaminal epidural injections are appropriate for the following therapeutic purposes:

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

PARAVERTEBRAL JOINT/NERVE BLOCKS – DIAGNOSTIC AND THERAPEUTIC

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

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

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

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

Indications for Paravertebral Facet Joint/Nerve Block:

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

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

Diagnostic Paravertebral Facet Joint/Nerve Block

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

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

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

Therapeutic Paravertebral Facet Joint/Nerve Block

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

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

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

PARAVERTEBRAL JOINT/NERVE DENERVATION

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

Indications for Paravertebral Joint/Nerve Denervation:

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

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

Limitations for Paravertebral Joint/Nerve Denervation:

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

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

SACROILIAC (SI) JOINT INJECTIONS

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

Indications for Sacroiliac (SI) Joint Injections:

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

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

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

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

Limitations for Sacroiliac (SI) Joint Injections:

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

ACUTE POST-OPERATIVE PAIN MANAGEMENT

Management of acute pain (obstetric, post-operative, or secondary to major trauma not requiring an operative procedure) in the hospital may be provided by several means: oral and parenteral administration of analgesics, intravenous patient controlled analgesia (PCA), and by the administration of epidural opiates or anesthetics.

Patient controlled analgesia is generally administered as an intravenous opiate infusion. The medication is available via an intravenous pump, and the patient can trigger the pump to deliver additional doses of medication based upon his/her individual threshold for pain, within the parameters programmed into the device.

Epidural analgesia may be provided by single injection or continuous infusion. It usually requires the placement of an epidural catheter, but may also be performed by a single injection. Epidural analgesia may be provided before or after a surgical procedure, but the advantage to pre-operative placement is that the patient is able to cooperate with the procedure, is not sedated from the operation and therefore is able to report any accompanying paresthesias, the catheter can be properly tested prior to surgery, and the patient will be able to receive pain medications via the epidural space prior to emergence from general anesthesia and may receive benefit from preemptive analgesia. Epidural anesthesia/analgesia commonly employs, in combination or as single agents: local anesthetics, opiates and opioids. Occasionally clonidine is used. Advantages of epidural analgesia include: less sedation, earlier mobilization, fewer respiratory complications, and preemptive analgesia. Catheters are usually left in place for three (3) days or less as the patients have usually recovered sufficiently to allow for removal. Patients with major abdominal or thoracic procedure may require longer infusion periods.

Indications for Acute Post-Operative Pain Management:

Epidural analgesia may be employed in obstetrical care and following major thoracic, intra-abdominal, radical pelvic cancer, aortic, retroperitoneal or orthopedic surgeries (hip and knee). It is seldom needed after laparoscopic surgeries for patients who are ambulated the same day.

Epidural analgesia may be employed for pain management in patients sustaining major non-operative trauma.

Reimbursement will be allowed for the initial insertion of the catheter by an anesthesiologist or CRNA on the date of surgery if performed for postoperative pain relief rather than as a measure for providing the regional block for surgical procedures.

Limitations for Acute Post-Operative Pain Management:

Except in special circumstances, payment for physician services related to patient controlled analgesia is included in the global fee paid to the surgeon. Routine management of PCA is not reimbursable to another physician or provider, and may not be billed as an anesthesia or evaluation and management (E&M) service. Prescription is part of the surgeon’s post-operative management and included in the global surgery.

Catheters placed in an operative site for infusion of a local anesthetic are included in the global surgical package.

Although the insertion of the epidural catheter is for the post-operative management of pain, the catheter may be utilized for the delivery of anesthetic during the surgical procedure if such use is only incidental to the general anesthesia. If it is used as the principal method of anesthesia, then it should be included as part of the surgical anesthesia care, and not separately billed. The catheter may be inserted prior to the onset of the surgical procedure (in the operating room) but this time should not be included in the time recorded for the anesthesia care for the surgery.

Anesthesia services provided by the performing surgeon are included in the global reimbursement for surgery, and neither the catheter placement (CPT code 62318 or 62319) nor the daily management of the administration of drugs is separately payable to the surgeon.

Daily management of epidural or subarachnoid drug administration is defined as a daily service and may only be billed by one provider other than the surgeon per day.

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 Determination Manual*, Chapter 1: Section 150.7)

CMS Publication100-08, *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 Part A MAC: This coverage determination also applies within states outside the primary geographic jurisdiction with facilities that have nominated CIGNA Government Services to process their claims.

Bill type codes only apply to providers who bill these services to the 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 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 likely, 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.

For outpatient settings other than CORFs, references to "physicians" throughout this policy include non-physicians, such as nurse practitioners, clinical nurse specialists and physician assistants. Such non-physician practitioners, with certain exceptions, may certify, order and establish the plan of care for pain management services as authorized by State law. (See Sections 1861[s][2] and 1862[a][14] of Title XVIII of the Social Security Act; 42 CFR, Sections 410.74, 410.75, 410.76 and 419.22; 58 FR 18543, April 7, 2000.)

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Coding Information

Bill Type Codes:

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

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 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
0490	Ambulatory Surgical Care - General Classification
0500	Outpatient Services - General Classification
0510	Clinic - General Classification
0520	Free-Standing Clinic - General Classification
0761	Specialty Services - Treatment Room
096X	Professional Fees - General Classification

CPT/HCPCS Codes	
GroupName	
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)
GroupName	
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'')
20551	INJECTION(S); SINGLE TENDON ORIGIN/INSERTION
20612	ASPIRATION AND/OR INJECTION OF GANGLION CYST(S) ANY LOCATION
28899	UNLISTED PROCEDURE, FOOT OR TOES
GroupName	
EPIDURAL AND INTRATHECAL INJECTIONS - INTERLAMINAR AND CAUDAL	
01966	ANESTHESIA FOR INDUCED ABORTION PROCEDURES
62310	INJECTION(S), OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S) (INCLUDING ANESTHETIC, ANTISPASMODIC, OPIOID, STEROID, OTHER SOLUTION), NOT INCLUDING NEUROLYTIC SUBSTANCES, INCLUDING NEEDLE OR CATHETER PLACEMENT, INCLUDES CONTRAST FOR LOCALIZATION WHEN PERFORMED, EPIDURAL OR SUBARACHNOID; CERVICAL OR THORACIC
62311	INJECTION(S), OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S) (INCLUDING ANESTHETIC, ANTISPASMODIC, OPIOID, STEROID, OTHER SOLUTION), NOT INCLUDING NEUROLYTIC SUBSTANCES, INCLUDING NEEDLE OR CATHETER PLACEMENT, INCLUDES CONTRAST FOR LOCALIZATION WHEN PERFORMED, EPIDURAL OR SUBARACHNOID; LUMBAR OR SACRAL (CAUDAL)
62318	INJECTION(S), INCLUDING INDWELLING CATHETER PLACEMENT, CONTINUOUS INFUSION OR INTERMITTENT BOLUS, OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S) (INCLUDING ANESTHETIC, ANTISPASMODIC, OPIOID, STEROID, OTHER SOLUTION), NOT INCLUDING NEUROLYTIC SUBSTANCES, INCLUDES CONTRAST FOR LOCALIZATION WHEN PERFORMED, EPIDURAL OR SUBARACHNOID; CERVICAL OR THORACIC

62319	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)

GroupName

EPIDURAL INJECTIONS – TRANSFORAMINAL

64479	INJECTION, ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); CERVICAL OR THORACIC, SINGLE LEVEL
64480	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)
64483	INJECTION, ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); LUMBAR OR SACRAL, SINGLE LEVEL
64484	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)

GroupName

EPIDURAL AND INTRATHECAL INJECTIONS - ACUTE POST-OPERATIVE CARE MANAGEMENT

01996	DAILY HOSPITAL MANAGEMENT OF EPIDURAL OR SUBARACHNOID CONTINUOUS DRUG ADMINISTRATION
62310	INJECTION(S), OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S) (INCLUDING ANESTHETIC, ANTISPASMODIC, OPIOID, STEROID, OTHER SOLUTION), NOT INCLUDING NEUROLYTIC SUBSTANCES, INCLUDING NEEDLE OR CATHETER PLACEMENT, INCLUDES CONTRAST FOR LOCALIZATION WHEN PERFORMED, EPIDURAL OR SUBARACHNOID; CERVICAL OR THORACIC
62311	INJECTION(S), OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S) (INCLUDING ANESTHETIC, ANTISPASMODIC, OPIOID, STEROID, OTHER SOLUTION), NOT INCLUDING NEUROLYTIC SUBSTANCES, INCLUDING NEEDLE OR CATHETER PLACEMENT, INCLUDES CONTRAST FOR LOCALIZATION WHEN PERFORMED, EPIDURAL OR SUBARACHNOID; LUMBAR OR SACRAL (CAUDAL)
62318	

	INJECTION(S), INCLUDING INDWELLING CATHETER PLACEMENT, CONTINUOUS INFUSION OR INTERMITTENT BOLUS, OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S) (INCLUDING ANESTHETIC, ANTISPASMODIC, OPIOID, STEROID, OTHER SOLUTION), NOT INCLUDING NEUROLYTIC SUBSTANCES, INCLUDES CONTRAST FOR LOCALIZATION WHEN PERFORMED, EPIDURAL OR SUBARACHNOID; CERVICAL OR THORACIC
62319	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)

GroupName

PARAVERTEBRAL JOINT/NERVE BLOCKS (DIAGNOSTIC AND THERAPEUTIC)

64490	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), CERVICAL OR THORACIC; SINGLE LEVEL
64491	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)
64492	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)
64493	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL; SINGLE LEVEL
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)

GroupName

PARAVERTEBRAL JOINT/NERVE DENERVATION

64999	UNLISTED PROCEDURE, NERVOUS SYSTEM

GroupName

SACROILIAC (SI) JOINT INJECTIONS

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

GroupName

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

GroupName

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 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
720.1	SPINAL ENTHESOPATHY
726.0	ADHESIVE CAPSULITIS OF SHOULDER
726.10	DISORDERS OF BURSAE AND TENDONS IN SHOULDER REGION UNSPECIFIED
726.11	CALCIFYING TENDINITIS OF SHOULDER
726.12	BICIPITAL TENOSYNOVITIS
726.13	PARTIAL TEAR OF ROTATOR CUFF
726.19	OTHER SPECIFIED DISORDERS OF BURSAE AND TENDONS IN SHOULDER REGION
726.2	OTHER AFFECTIONS OF SHOULDER REGION NOT ELSEWHERE CLASSIFIED
726.30	ENTHESOPATHY OF ELBOW UNSPECIFIED
726.31	MEDIAL EPICONDYLITIS
726.32	LATERAL EPICONDYLITIS
726.33	OLECRANON BURSITIS
726.39	OTHER ENTHESOPATHY OF ELBOW REGION
726.4	ENTHESOPATHY OF WRIST AND CARPUS
726.5	ENTHESOPATHY OF HIP REGION
726.60	ENTHESOPATHY OF KNEE UNSPECIFIED
726.61	PES ANSERINUS TENDINITIS OR BURSITIS
726.62	TIBIAL COLLATERAL LIGAMENT BURSITIS
726.63	FIBULAR COLLATERAL LIGAMENT BURSITIS
726.65	PREPATELLAR BURSITIS
726.69	OTHER ENTHESOPATHY OF KNEE
726.70	ENTHESOPATHY OF ANKLE AND TARSUS UNSPECIFIED
726.71	ACHILLES BURSITIS OR TENDINITIS
726.72	TIBIALIS TENDINITIS
726.73*	CALCANEAL SPUR
726.79*	OTHER ENTHESOPATHY OF ANKLE AND TARSUS

726.8	OTHER PERIPHERAL ENTHESOPATHIES
727.00	SYNOVITIS AND TENOSYNOVITIS UNSPECIFIED
727.01	SYNOVITIS AND TENOSYNOVITIS IN DISEASES CLASSIFIED ELSEWHERE
727.02	GIANT CELL TUMOR OF TENDON SHEATH
727.03	TRIGGER FINGER (ACQUIRED)
727.04	RADIAL STYLOID TENOSYNOVITIS
727.05	OTHER TENOSYNOVITIS OF HAND AND WRIST
727.06	TENOSYNOVITIS OF FOOT AND ANKLE
727.09	OTHER SYNOVITIS AND TENOSYNOVITIS
727.1	BUNION
727.2	SPECIFIC BURSITIDES OFTEN OF OCCUPATIONAL ORIGIN
727.3*	OTHER BURSITIS DISORDERS
727.40	SYNOVIAL CYST UNSPECIFIED
727.41	GANGLION OF JOINT
727.42	GANGLION OF TENDON SHEATH
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

EPIDURAL 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-THORACOTOMY PAIN
338.18	OTHER ACUTE POSTOPERATIVE PAIN
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
353.6	PHANTOM LIMB (SYNDROME)
354.4	CAUSALGIA OF UPPER LIMB
355.71	CAUSALGIA OF LOWER LIMB
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.)

EPIDURAL INJECTIONS – TRANSFORAMINAL (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
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

EPIDURAL 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-THORACOTOMY 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 MONOPLEGIA
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	MONOPLEGIA OF LOWER LIMB AFFECTING DOMINANT SIDE
344.32	MONOPLEGIA OF LOWER LIMB AFFECTING NONDOMINANT SIDE
344.41	MONOPLEGIA OF UPPER LIMB AFFECTING DOMINANT SIDE
344.42	MONOPLEGIA OF UPPER LIMB AFFECTING NONDOMINANT SDE
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
Back to Top

General Information

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 (> /=) 80%-90% initially with the ability to perform previously painful maneuvers, and persistent pain relief is defined as a minimum of six (6) weeks of >/= 50% relief with the continued ability to perform previously painful maneuvers.
- 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 (cerviocothoracic 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 (>/=)80%-90% with the ability to perform previously painful maneuvers, and a persistent pain relief of >/=50% with the continued ability to perform previously painful maneuvers is maintained for at least six weeks. The therapeutic frequency must remain at least two months or longer for each region.
- In the treatment or therapeutic phase, the interventional procedures should be repeated only as medically necessary. No more than four therapeutic injections of any type (interlaminar or caudal epidural, transforaminal epidural, paravertebral facet joint or nerve, and/or sacroiliac joint) per region per patient per year are anticipated for the majority of patients.
    - Under unusual circumstances with a recurrent injury, carcinoma, or reflex sympathetic dystrophy, blocks may be repeated more frequently in the treatment phase after diagnosis/stabilization.
- Blind interlaminar or caudal epidurals are repeated only following appropriate response of at least four weeks. Failure to obtain appropriate response may indicate improper delivery of the drug and/or presence of a pain generator, which is non-responsive to epidural injection. Thus, subsequent epidural injections after a failed or inadequate response, if performed, should be under fluoroscopic visualization.
- Only paravertebral facet joint/nerves for which there has been a positive response should be injected for therapeutic reasons. No more than two, and occasionally three unilateral or bilateral joint/nerve injections per region would be anticipated per date of service.
- Only paravertebral facet joints for which there has been a positive response to at least two double-comparative local anesthetic injections should be denervated.
- Claims billed for denervation procedures performed more frequently than once every six months at the same target level must be supported by documentation describing the unusual clinical circumstances and response to prior therapy(ies).
- Only sacroiliac joints for which there has been a positive response should be injected for therapeutic reasons.

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).

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Advisory Committee Meeting Notes

Start Date of Comment Period

End Date of Comment Period

Start Date of Notice Period

Revision History Number R5

Revision History Explanation Revision #: R5
Revision Effective Date: 01/01/2012
Revsion Explanantion: The following CPT/HCPCS codes were deleted:
64622 was deleted from Group 7 and replace with 64635
64623 was deleted from Group 7 and replaced with 64636
64626 was delted from group 7 and replaced with 64633
64627 was deleted from group 7 and replaced with 64634

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

Revision Effective date: 10/17/11
Revision Explanation: Added MAC Part A Contractor #'s 15101 and 15201 to all MAC Part B Contractor # 15102 LCDs. Contractors 15101 and 15201 will be part of the Jurisdiction 15 MAC Contract as of October 17, 2011.

Revision#:R4
Revision Effective date: 10/01/11
Revision Explanation: Added 726.13 as covered diagnosis as part of the 2012 icd.9 updates

Revision#:R3
Revision Effective date: 10/17/11
Revision Explanation: Added the following Part A revenue code per CMD, Dr. Pilley's request: 0490, 0500, 0510, 0520. This code will become effective for CGS with the Part A transition.

Revision#:R2
Revision Effective date: 06/18/11
Revision Explanation: Added MAC Part B Contractor # 15202 to all MAC Part B Contractor # 15102 LCDs. Contractor 15202 will be part of the Jurisdiction 15 MAC Contract as of June 18, 2011.

Revision #:R1
07 March 2011 Added NCD 160.1 to CMS National Coverage Policy Tab.

This LCD was converted from L28529 for Jurisdiction 15 A/B MAC on 04/30/2011.
All prior notes were retained with the previous carriers version that has been archived in the Medicare Coverage Database.

07/02/2011 - The J15 Contractor adopted a new business name. This LCD revision only includes the change from CIGNA Government Services to CGS Administrators, LLC. No coverage information was included in this revision and no provider action is needed regarding this revision.

Reason for Change

Related Documents

Article(s)

A50838 - Pain Management – Supplemental Instructions Article

LCD Attachments

There are no attachments for this LCD.

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All Versions

Updated on 12/13/2011 with effective dates 01/01/2012 - N/A
Updated on 12/12/2011 with effective dates 01/01/2012 - N/A
Updated on 09/27/2011 with effective dates 10/17/2011 - 12/31/2011
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