Children's Hospital and Health System
Chorus Community Health Plans
Policy and Procedure

This policy applies to the following entity(s):

☐ CHW – Milwaukee	☐ CHW - Fox Valley
☐ CHHS Foundation	☐ CHW - Surgicenter
☐ CHW – Community Services Division	☒ Chorus Community Health Plans
☐ Children's Medical Group - Primary Care	☐ Children's Specialty Group
☐ Children's Medical Group - Urgent Care	☐ CHHS Corporate Departments

Medical Utilization Management Policy

SUBJECT: EPIDURAL CORTICOSTEROID INJECTIONS FOR SPINAL PAIN

INCLUDED PRODUCT(S):

Medicaid	Individual and Family
☒ BadgerCare Plus	☒ Commercial
☒ Care4Kids Program	☒ Marketplace

PURPOSE OR DESCRIPTION:

The purpose of this policy is to define criteria for the medically necessary use of epidural injections of corticosteroids (ESI) for spinal pain.

POLICY:

I. For lumbar and cervical ESI, the following clinical criteria are required to determine if an ESI is medically necessary:

- Epidural corticosteroid injection may be indicated when **ALL** of the following are present
  - Radicular pain, as indicated by **1 or more** of the following:
    - Cervical radicular pain (e.g., arm or neck pain, paresthesia)
    - Lumbar radicular pain (e.g., leg pain or paresthesia)
  - Failure of noninvasive treatment (e.g., NSAIDs, exercise, physical therapy, spinal manipulation therapy)
  - Goal of treatment is short-term relief of disabling pain.

- Signs or symptoms consistent with radiculopathy, as indicated by **1 or more** of the following:
  - Diminished deep tendon reflexes on physical exam
  - Parasthesias, numbness, sensory change, or weakness in dermatomal distribution that is concordant with the proposed side and level of ESI.
  - Positive Spurling test (for cervical spine)
  - Positive femoral nerve stretch test (for lumbar spine)
  - Positive straight-leg-raising test (for lumbar spine)
  - Positive slump test (for lumbar spine)
- No acute spinal cord compression
- No coagulopathy or current use of anticoagulants or antiplatelet therapy without a documented plan to hold prior to the procedure or determined safe to proceed
- No local malignancy
- No local or systemic infection

Because symptoms evolve over time and patients may experience spontaneous resolution of problems, clinical documentation supporting medical necessity must be dated within 3 months of the date of the initial proposed ESI procedure. In addition, this supporting documentation must be dated within 6 months of subsequent planned procedures. CCHP considers more than 3 ESI procedures in 12 months, at the same level regardless of side (left or right) and regardless of approach (caudal, transforaminal, or intralaminar)as not medically necessary. Provided the request meets all the foregoing requirements, CCHP will approve up to 3 ESI procedures in a single prior authorization request.

II. For ESI for thoracic spinal pain there is insufficient evidence of benefit over harm. Therefore thoracic ESI procedures will not be considered medically necessary.

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