Clinical Policy: Intradiscal Steroid Injections for Pain Management

Reference Number: LA.CP.MP.167 Coding Implications
Date of Last Revision: 9/2022 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Intradiscal steroid injections involve injecting glucocorticoids directly into the spinal disc that has been identified as the source of pain.

Policy/Criteria
I. It is the policy of Louisiana Healthcare Connections that intradiscal steroid injections are considered not medically necessary because effectiveness has not been established. The published literature suggests both positive and negative results. Further research is being done to determine the safety and efficacy of injecting steroids directly into the disc.

Background
There is limited and conflicting evidence regarding the effectiveness of intradiscal glucocorticoids for low back pain.[1] In patients with magnetic resonance imaging (MRI) evidence of degenerative disc disease and a positive response to discography, two trials found no difference between intradiscal steroid and control injection (saline or local anesthetic).[1] A third trial found that in patients with degenerative disc disease who failed an epidural steroid injection, intradiscal steroid injection was superior to discography alone only in the subgroup of patients with inflammatory endplate changes on MRI.[1] However, outcomes were not well defined in this trial and levels of statistical significance were poorly reported. Based on these trials, the American Pain Society guideline recommends against intradiscal glucocorticoid injection for presumed discogenic pain.[2]

A randomized trial of 135 patients with active discopathy treated with a glucocorticoid intradiscal injection during discography or discography alone, found that back pain was improved at one month in the intradiscal injection group, but the effect was not present at 12 months.[3] Secondary outcomes such as activity limitations, use of analgesics, quality of life, and anxiety and depression did not differ between the treatment and control groups at either evaluated time point.[3]

The use of intradiscal steroid injections is also debated because intradiscal steroid may cause discitis, progression of disc degeneration, and calcification of the intervertebral disc.[1]

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019 American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only and may not support medical necessity. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources

of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
22899	Unlisted procedure, spine

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria
+ Indicates a code requiring an additional character

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Converted corporate to local policy.	08/15/2020	
Annual review. Changed "review date" in the header to "date of last revision" and "date" in the revision log header to "revision date." References reviewed, reformatted and updated. Specialist review.	1/2022	
Annual Review. Replaced "member" with "member/enrollee" in all instances. Background updated with no impact on criteria. References reviewed and updated. Specialist reviewed.	9/22	

References

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.