EPIDURAL INJECTION

Guideline Number: MPG100.04  Approval Date: November 14, 2018

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POLICY SUMMARY

Overview
The physician injects an anesthetic agent and/or a long-acting corticosteroid into the area between the protective covering of the spinal cord (dura) and the bony vertebrae of the cervical, thoracic, lumbar, or sacral spine. Nerve roots enter the body after exiting the spinal canal through tiny openings between the vertebrae (foraminae). Using ultrasound guidance, the physician injects the appropriate substance between the foraminae into the area around a selected nerve root.

Guidelines
Transforaminal epidural injections with ultrasound guidance (CPT codes 0228T-0231T) will be denied as investigational.

APPLICABLE CODES

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>0228T</td>
<td>Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level</td>
</tr>
<tr>
<td>0229T</td>
<td>Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>0230T</td>
<td>Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level</td>
</tr>
<tr>
<td>0231T</td>
<td>Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure)</td>
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</tbody>
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* CPT® is a registered trademark of the American Medical Association

PURPOSE

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers’ submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.
UnitedHealthcare follows Medicare guidelines such as LCDs, NCDs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

REFERENCES

CMS Local Coverage Determinations (LCDs)

<table>
<thead>
<tr>
<th>LCD</th>
<th>Medicare Part A</th>
<th>Medicare Part B</th>
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<tbody>
<tr>
<td>L3392 (Category III CPT® Codes) NGS</td>
<td>CT, IL, MA, ME, MN, NH, NY, RI, VT, WI</td>
<td>CT, IL, MA, ME, MN, NH, NY, RI, VT, WI</td>
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<tr>
<td>L34555 (Non-Covered Category III CPT Codes) Palmetto</td>
<td>AL, GA, NC, SC, TN, VA, WV</td>
<td>AL, GA, NC, SC, TN, VA, WV</td>
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<td>L33777 (Noncovered Services) First Coast</td>
<td>FL, PR, VI</td>
<td>FL, PR, VI</td>
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<tr>
<td>L35094 (Services That Are Not Reasonable and Necessary) Novitas</td>
<td>AR, CO, DC, DE, LA, MD, MS, NM, NJ, OK, PA, TX</td>
<td>AR, CO, DC, DE, LA, MD, MS, NM, NJ, OK, PA, TX</td>
</tr>
</tbody>
</table>

MLN Matters

Article SE1102, Inappropriate Medicare Payments for Transforaminal Epidural Injection Services

UnitedHealthcare Commercial Policies

Epidural Steroid and Facet Injections for Spinal Pain

GUIDEline HISTORY/REVISION INFORMATION

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
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<tbody>
<tr>
<td>04/01/2019</td>
<td>• Reorganized policy template; relocated Terms and Conditions and Purpose section</td>
</tr>
</tbody>
</table>
| 11/14/2018 | • Annual review  
• Administrative updates |

TERMS AND CONDITIONS

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of
publication, and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

Medicare Advantage Policy Guidelines are the property of UnitedHealthcare. Unauthorized copying, use and distribution of this information are strictly prohibited.

*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.