

**American Society of Interventional Pain Physicians®**  
**Society of Interventional Pain Management Surgery Centers Inc.**  
**"The Voice of Interventional Pain Management"**

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July 12, 2021

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RE: Proposed Local Coverage Determination (LCD): Epidural Procedures for Pain Management (DL36920)

On behalf of the Arkansas, Colorado, Delaware, Louisiana, Maryland, Mississippi, New Jersey, New Mexico, Oklahoma, Pennsylvania, and Texas Societies of Interventional Pain Physicians, the American Society of Interventional Pain Physicians (ASIPP), and the Society of Interventional Pain Management Surgery Centers (SIPMS), we would like to thank you for publishing the proposed LCD for epidural procedures for pain management in multiple jurisdictions with the same document. We appreciate all your hard work, multijurisdictional committee meetings, and extensive review of the literature.

The proposed policy requires significant revisions and amendments in four (4) important areas:

1. Inclusion of percutaneous adhesiolysis, which has been discussed in multijurisdictional committee with a score of 3.21. In addition, appropriate literature analysis based on relevant randomized controlled trials (RCTs) (1-11), systematic reviews and guidelines (12-17) shows Level I to Level II evidence with strong to moderate recommendation (17).
2. Please revise the coverage indications with the replacement of radiculopathy with radicular pain and limiting these indications for transforaminal epidural injections with addition of disc herniation to present indications. In addition, the covered indications must include degenerative disc disease, spinal stenosis, post surgery syndrome, and discogenic pain without evidence of facet joint or sacroiliac joint pain as they have been covered in the previous LCDs with an abundance of evidence (17-52).

The evidence for multiple degenerative conditions and discogenic pain without facet joint or sacroiliac joint pain has been presented in multiple randomized controlled trials, systematic reviews, and guidelines with a multijurisdictional committee score of 3.43 (17,18,22,32,41,44,47,50).

3. Please revise procedural limitations and outcomes assessment in reference to the duration of relief, with expansion, similar to the previous LCD, with 2 procedures in the diagnostic or initial phase with 4 and 6 weeks apart after first and second procedures per spinal region, followed by 4 epidural injections per spinal region in a rolling year, initiated with a third procedure. If the patients' condition includes an acute lumbar herniated nucleus pulposus, then the patient should wait no longer than 2 weeks for the first epidural steroid injection and no longer than 2 weeks for a second and or third epidural steroid injection, if indicated. Additionally, to provide a second epidural after 3 months of sustained 50% pain

relief is not supported by the literature. An overwhelming evidence in the literature shows the first procedure providing  $5.69 \pm 8.23$  in 1,510 patients assessed and the second procedure providing  $10.02 \pm 12.57$  weeks assessed in 1,402 patients (40-52). In addition, multiple other studies, including the study by Friedly et al (53), also shows 6 weeks of relief rather than 3 months of relief.

4. Coverage for multiple procedures in separate regions in the same session when reasonable and necessary.

## **BACKGROUND**

ASIPP is a not-for-profit professional organization founded in 1998 now comprising over 4,500 interventional pain physicians and other practitioners who are dedicated to ensuring safe, appropriate, and equal access to essential pain management services for patients across the country suffering with chronic and acute pain. There are approximately 8,500 appropriately trained and qualified physicians practicing interventional pain management in the United States. ASIPP is comprised of 50 affiliated state societies, and the Puerto Rico Society of Interventional Pain Physicians.

Interventional pain management is defined as the discipline of medicine devoted to the diagnosis and treatment of pain related disorders principally with the application of interventional techniques in managing sub acute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatment (54).

Interventional pain management techniques are minimally invasive procedures including, percutaneous precision needle placement, with placement of drugs in targeted areas or ablation of targeted nerves; and some surgical techniques such as laser or endoscopic discectomy, intrathecal infusion pumps and spinal cord stimulators, for the diagnosis and management of chronic, persistent or intractable pain (55).

SIPMS is a not-for-profit professional organization founded in 2005, with membership involving surgical centers focusing on interventional pain management, dedicated to ensuring safe, appropriate, and equal access to essential pain management services for patients across the country suffering with chronic pain. There are approximately 500 surgery centers across the nation approved by Medicare providing solely, or an overwhelming majority, of interventional pain management services.

## **Medicare**

Based on the 21<sup>st</sup> Century Cures Act of 2016, the LCD process is updated to provide greater transparency, consistency, and patient engagement.

Medicare covers medically reasonable and necessary services. If the service is:

- Safe and effective;
- Not experimental or investigational; and
- Appropriate, including the duration and frequency in terms of whether the service or item is:
  - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the beneficiary's condition or to improve the function of a malformed body member;
  - Furnished in a setting appropriate to the beneficiary's medical needs and condition;
  - Ordered and furnished by qualified personnel

Further, LCD development process must assure beneficiary access to care.

The National Contractor Advisory meeting consisting of national experts, geographic representation, academic and clinical practice, various specialties that perform are involved in the procedure, have

performed evidence-based review. American Society of Interventional Pain Physicians through its multiple CAC members and subject matter experts, have participated in National Contractor Advisory Committee meeting for policy development. Based on the hierarchy of evidence review, an overwhelming majority of the procedures received recommendations based on randomized controlled trials, appropriately performed systematic reviews and meta-analysis, and evidence-based clinical practice guidelines, rather than consensus based guidance.

## **DISCUSSION OF THE ISSUES**

### **PERCUTANEOUS ADHESIOLYSIS**

There was an LCD request for percutaneous adhesiolysis at CGS. Subsequently, it was incorporated into multijurisdictional committee assessment as an epidural intervention. Percutaneous adhesiolysis is an epidural intervention, which differs from epidural injections with additional involvement of catheter-based adhesiolysis. It fits the criteria of the epidural intervention as described in evidence-based guidelines (17). Based on multiple moderate to high-quality RCTs and systematic reviews (1-17), the evidence was shown to be Level I with strong recommendation in evidence-based guidelines (17) for long-term improvement of post lumbar surgery syndrome after failure of conservative management and fluoroscopically-guided epidural injections. The evidence for lumbar central spinal stenosis based on relevant, moderate to high-quality RCTs, observational studies, and systematic reviews was Level II with moderate to strong recommendation in patients nonresponsive to conservative management and fluoroscopically guided epidural injections. The evidence was Level II with moderate to strong recommendation for long-term improvement in patients nonresponsive to conservative management and fluoroscopically guided epidural injections with one high-quality, placebo-controlled RCT and multiple large scale observational studies for recalcitrant disc herniation in patients (5,15,56-60). To summarize, epidural adhesiolysis has been studied in multiple randomized controlled trials (1-11) and multiple systematic reviews and meta-analyses have been performed (12-17). Of 5 available systematic reviews, one showed negative results and all others showed positive results in post lumbar surgery syndrome, central spinal stenosis, and refractory disc herniation.

Further, subject matter experts and Carrier Advisory Committee (CAC) member survey of the multijurisdictional committee scored 3.21 on a scale of 1 to 5.

Lack of addition to this procedure will be significantly consequential. As of now, Palmetto and Noridian have issued non-coverage determinations (NCDs). In other jurisdictions, this procedure is offered; however, with the publication of epidural policy it may encourage other jurisdictions to do the same. Now which is a differential decline in access will become a universal decline in access. In addition, percutaneous adhesiolysis procedure, which is performed only after failure of fluoroscopically directed epidural injections, may reduce other expensive modalities including repeat surgical interventions, spinal cord stimulation, intrathecal infusion systems, and increased opioid prescriptions. The cost utility analysis have shown similar cost utility compared to other modalities. This may also lead to utilization and continuation of transforaminal epidural injections, which cost the same to Medicare or less with approval of percutaneous adhesiolysis.

Based on Medicare Integrity Manual, Chapter 13, Section 13.5.4, Reasonable and Necessary Criteria to be Included in an LCD, are met. In addition, it is crucial to retain this procedure as one of the hallmarks of LCD development process is: “assuring beneficiary access to care.”

## COVERED INDICATIONS

The policy states the following:

- “• **Lumbar, cervical, or thoracic radiculopathy and/or neurogenic claudication due to central disc herniation, osteophyte or osteophyte complexes, severe degenerative disc disease, producing foraminal or central stenosis<sup>5</sup> OR**
- **Post laminectomy syndrome,<sup>6,7,8</sup> OR**
- **Acute herpes zoster associated pain.<sup>6</sup>**

**AND**

- **Radicular pain is severe enough to cause a significant degree of functional disability or vocational disability measured at baseline using an objective pain scale\*. A functional assessment scale must be performed at baseline if function is considered as part of the assessment.**

**AND**

- **Pain duration of at least four (4) weeks, and the inability to tolerate noninvasive conservative care or medical documentation of failure to respond to four (4) weeks of noninvasive conservative care or acute herpes zoster refractory to conservative management where a four (4) week wait is not required.<sup>9</sup>”**

These indications may be appropriate for transforaminal epidural injections with appropriate language revisions to radicular pain. However, the indications for interlaminar and caudal epidural injections should be expanded.

Radiculopathy should be replaced with radicular pain. Often these terms are used interchangeably. All types of procedures have been shown to be effective in managing radicular pain, even though the evidence is somewhat better for transforaminal epidural injections and transforaminal epidural injections are indicated only when there is radicular pain. However, there is no evidence of any of the procedures in managing radiculopathy.

As you know, most patients with severe radicular pain do not have physical examination or imaging abnormalities. Neurological deficits are not common and are not necessary to support a diagnosis of radicular pain. In addition, the specificity and sensitivity of neurological examination with straight leg raising and motor dysfunction are nonspecific. Imaging findings also may be variable with or without mechanical nerve compression.

Consequently, we request that this be revised as follows:

History and/or physical examination, and diagnostic imaging supporting one of the following: lumbar, cervical, or thoracic radicular pain.

We request the addition of disc herniation and degenerative disc disease as causative factors.

While all types of procedures may be performed; however, for transforaminal epidural injections, these indications must be limited. Further, for interlaminar and caudal epidural injections, the indications should be expanded as covered previously with degenerative disc disease, disc herniation, spinal stenosis without neurogenic claudication or radicular pain, and discogenic pain without facet joint or sacroiliac joint pain.

The literature on disc herniation is extensive similar to the radicular pain as shown above (45,46,49,61-79).

Degenerative disc disease without radicular pain is common and has been treated with epidural injections over the years. It is difficult to isolate these patients from others in various studies published. However, these have been covered in previous LCDs, even the present LCD shows some of the indications. Post surgery syndrome may also present without radicular pain and may not have facet joint or sacroiliac joint pain.

Discogenic pain without facet joint or sacroiliac joint pain has been shown to be well managed with epidural injections (17,18,21,31,41,44,47,50). Clinical and cost utility analysis show similar effectiveness as in disc herniation or spinal stenosis or post lumbar surgery syndrome. Consequently, degenerative disc disease without radicular pain, spinal stenosis without neurogenic claudication, post surgery syndrome without radicular pain, and discogenic pain without facet joint or sacroiliac joint pain must be covered. Failure to do so will leave majority of the patients without any further treatment (80-83). Based on facet joint policy, patients not achieving 80% relief on 2 consecutive comparative local anesthetic blocks will be judged as negative for facet joint pain and will be positive and responsive to interlaminar or caudal epidural injections, as shown in the literature, systematic reviews and guidelines, with a multijurisdictional committee score of 3.43 (17,18,21,31,41,44,47,50).

**Pain duration of at least 4 weeks** and the inability to tolerate non-invasive conservative care or medical documentation of failure to respond to 4 weeks of non-invasive conservative care should be eliminated for acute radicular pain, similar to acute herpes zoster. Acute radicular pain and acute herpes zoster may be treated after 1-2 weeks of non-invasive conservative care.

Under covered indications #4: Caudal epidural steroid injections (CESI) and interlaminar epidural steroid injections involving a maximum of one level are considered medically reasonable and necessary.

We request this to be revised to caudal epidural injections and interlaminar epidural injections involving a maximum of one level per region are considered medically reasonable and necessary.

Under covered indications #6, this has been discussed above in reference to the relief.

Under covered indications #7 which describes ESIs injectants must include corticosteroids, anesthetics, anti-inflammatories, and/or contrast agents.

Please reword this as: Epidural injectates must include either corticosteroids, anesthetics, anti-inflammatories, or contrast agents or combination thereof.

This will avoid the confusion in reference to that corticosteroids are mandated.

We request that approved codes should be revised with addition of degenerative disc disease codes and disc herniation codes as follows:

Further, approved codes do not include degenerative disc disease and disc herniation. Consequently, please add the following:

- M50.21 Other cervical disc displacement, high cervical region
- M50.221 Other cervical disc displacement at C4-C5 level
- M50.222 Other cervical disc displacement at C5-C6 level
- M50.223 Other cervical disc displacement at C6-C7 level
- M50.23 Other cervical disc displacement, cervicothoracic region

M50.31 Other cervical disc degeneration, high cervical region  
M50.321 Other cervical disc degeneration at C4-C5 level  
M50.322 Other cervical disc degeneration at C5-C6 level  
M50.323 Other cervical disc degeneration at C6-C7 level  
M50.33 Other cervical disc degeneration, cervicothoracic region

M51.24 Other intervertebral disc displacement, thoracic region  
M51.25 Other intervertebral disc displacement, thoracolumbar region  
M51.34 Other thoracic disc degeneration, thoracic region  
M51.35 Other thoracic disc degeneration, thoracolumbar region

M51.26 Other intervertebral disc displacement, lumbar region  
M51.27 Other intervertebral disc displacement, lumbosacral region  
M51.36 Other intervertebral disc degeneration, lumbar region  
M51.37 Other intervertebral disc degeneration, lumbosacral region

## **PROCEDURAL LIMITATIONS AND OUTCOMES ASSESSMENT**

### **Outcomes Assessment**

The policy at present limits the second procedure based on 50% improvement for 3 months, which is non-achievable and non-evidence based statement. As we have described, analysis of 13 randomized controlled trials (40-52) with inclusion of 1,510 patients showed the relief following first procedure of  $5.69 \pm 8.23$  weeks. The same studies also showed the relief after the second procedure of  $10.02 \pm 12.57$  weeks with inclusion of 1,402 patients, as shown in attached Tables 1, 2, and 3. This assessment was carried out for 2-year period, except in one study where it was limited to one-year. Further, study by Friedly et al (53) also showed less than 6 weeks of relief with one injection.

These criteria in conjunction with covered indications will eliminate majority of the patients receiving epidural injections. This may range as high as 90%. This will create a major access issue and various issues related to opioid epidemic and explosion of more expensive procedures.

Consequently, we request you replace this language as follows with expansion, similar to the previous LCDs:

With 2 epidural injections in the diagnostic or initial phase with 4 and 6 weeks apart after first and second procedures per spinal region, followed by 4 epidural injections per spinal region in a rolling year, initiated with a third procedure.

**Under Limitations #5, ESIs** to treat non-specific low back pain (LBP), axial spine pain, complex regional pain syndrome, widespread diffuse pain, pain from neuropathy from other causes, cervicogenic headaches are considered investigational and therefore are not considered medically reasonable and necessary.

As we have discussed above, please revise this limitation to epidural injections to treat non-specific low back pain, widespread diffuse pain, are considered investigational and therefore are not considered medically reasonable and necessary.

As described earlier, axial spine pain without facet joint or sacroiliac joint pain, complex regional pain syndrome, neuropathy from other causes, and cervicogenic headaches are responsive to epidural injections. These are performed in a minority of cases. There is no reason to restrict patient access in these areas.

**Under Limitations #12**, steroid dosing should be the lowest effective amount and not to exceed 40mg for methyl prednisone, 10-20mg for triamcinolone acetate, and 10mg (10mg/mL) for dexamethasone phosphate per session.

These doses may not be accurate. Further, the described dosages in multijurisdictional committee and extensive literature are different.

Consequently, we request this section to be changed as follows:

Steroid dosing should be the lowest effective amount and not to exceed 80 mg of triamcinolone, 80 mg of methylprednisolone, 12 mg of betamethasone, and 16 mg of dexamethasone per session.

**Under Limitations #13**, this limitation must be removed. This is not appropriate as discussed above.

### **MULTIPLE TREATMENTS**

The policy states no multiple treatments can be performed. We can understand that in a single region there may not be multiple procedures; however, when these are performed in different regions there is no basis for this. In general, literature shows that 60% of the patients with spinal pain have more than one region involved. Consequently, this will significantly restrict the access. It also causes patient inconvenience, provider increased workload and costs, and finally it is more expensive to the program with payment of 200% instead of 150%.

Unintended consequence of this will include Medicare Advantage Plans going to the same with high copays and deductibles doubling the pain.

Further, all government plans, Medicaid, commercial payers also follow this. Apart from expense, it will result in significant lack of access, with expenses, family involvement with transportation, and multiple COVID tests. In addition, we also have concerns with regards to long-term treatment and restrictions.

### **Treatments Exceeding 12 Months**

This limitation is unreasonable and the requirements add significant documentation burden, and also affects the access. The LCD already has sufficient guardrails in place to prevent overuse or abuse of the procedure while outlining appropriate use and thus we request that this limitation #13 that limits epidurals to 12 months be removed.

As long as a physician documents medical necessity as described in the LCD with appropriate improvement, that should suffice.

### **Other Issues Contrast**

Contrast injection may be reworded with except for patients who have a documented contrast allergy or are pregnant.

### **Epidural Steroid Nomenclature**

The policy calls for epidural steroid injections; however, if epidurals do not include steroids, they are not epidural steroid injections and the language may be changed to epidural procedure or epidural injection.

### **Conservative Management**

While some patients benefit from multimodal treatments, others who experience relief from epidural injections may not require additional conservative management, except for structured exercise program.

Consequently, the language may be changed allowing for epidural procedures to be performed in conjunction with conservative treatments.

### **Summary and References**

There are a multitude of errors in the references. Even though summary is extensive, it does not include appropriate references. It will be too extensive to include. If you need further assistance on these issues, we will be happy to provide you with the appropriate positioning of the references.

### **CONCLUSION**

To summarize, failure to provide appropriate care to these patients will lead to more expensive treatments and hinder the access and may fuel opioid epidemic in addition to explosion of modalities such as spinal cord stimulation, intrathecal infusion system implantables, PILD procedure, interspinous prosthesis implants, and finally surgical interventions. In addition to this, it will increase the expenses to the program as described earlier and also reduce the access significantly, not only to Medicare patients, but also Medicare Advantage, all governmental programs, Medicaid, and finally commercial insurers. It will cause substantial inconvenience to the patients with multiple copays, difficulties with drivers bringing them to the procedures, and multiple COVID tests. In essence, this policy will hurt the most vulnerable, namely the elderly, economically disadvantaged, and minority population which is quite opposite the goals of Medicare program.

In reference to the inclusion criteria, it will be cost effective to utilize clinically effective modalities while maintaining the access and without fueling the opioid epidemic and increasing health care costs exponentially.

Criteria should also increase appropriate diagnosis for treatment of complex regional pain syndrome (CRPS), cervicogenic headache, and neuropathic pain. The expenditures for Medicare will be similar whether these patients are treated with epidurals or sympathetic blocks.

Thank you again for all your dedication. We hope these comments will be helpful in revising the LCD, which will be acceptable to all involved, which will not only improve the patient care, but within the parameters of Chapter 13 of Medicare Program Integrity Manual and Medicare's promise to provide appropriate care to elderly.

### **ASIPP, SIPMS, AND STATE SOCIETIES**



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