Priority Health	BILLING POLICY No. 100

EPIDURAL STEROID INJECTION FOR PAIN MANAGEMENT (ESI)

Effective date: Aug. 25, 2025 **Date of origin: June 19, 2025**	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

This policy outlines billing guidelines related to **Epidural Steroid Injection for Pain Management (ESI)**: The administration via injection of contrast, followed by an injection of a corticosteroid and possibly a local anesthetic into the epidural space of the spine.

MEDICAL POLICY

- Spine Procedures (#91581)

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

- Only 1 spinal region may be treated per session (date of service)
- CPT codes 64479, 64480, 64483 and 64484. only 2 total levels per session are allowed for (2 unilateral or 2 bilateral levels)
- CPT code 64480 should be reported in conjunction with 64479
- CPT code 64484 should be reported in conjunction with 64483
- CPT codes 62321 and 62323 may only be reported for 1 level per session
- CPT codes 62321, 62323, 64479, 64480, 64483 and 64484 No more than 4 epidural injection sessions per spinal region in a 12-month period regardless of the number of levels involved.

Reimbursement rates

Find reimbursement rates for the codes listed in this policy in our standard fee schedules for your contract. See our fee schedules (login required).

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Learn more about modifier use in our Provider Manual.

- **50**: bilateral procedure: unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50
- **KX**: requirements specified in the medical policy have been met
- **LT**: left side (used to identify procedures performed on the left side of the body)
- **RT**: right side (used to identify procedures performed on the right side of the body)

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Ger more information in our Provider Manual .

REFERENCES

- Article – Billing and Coding: Epidural Steroid Injections for Pain Management (A58777) (CMS)

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made