Clinical Policy: Selective Nerve Root Blocks and Transforaminal Epidural Steroid Injections

Reference Number: CP.MP.165
Date of Last Revision: 07/26

Coding Implications
Revision Log

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

Description
Transforaminal epidural steroid injections (TFESIs) and selective nerve root blocks (SNRBs) are alternatives to interlaminar epidural steroid injections for the treatment of radicular pain. SNRBs consist of a small amount of local anesthetic injected adjacent to a spinal nerve root and are most often used to diagnose the source of pain.[1] During a TFESI, a larger amount of local anesthetic or corticosteroid is injected into the intervertebral foramen, where the injectate spreads to target multiple nerves. SNRBs and TFESIs share similar safety considerations, procedural techniques, and anatomical benchmarks.[1]

Note: For guidelines for caudal or interlaminar epidural steroid injections (ESIs), reference *CP.MP.164 Caudal or Interlaminar Epidural Steroid Injections.*

Policy/Criteria
It is the policy of health plans affiliated with Centene Corporation® that invasive pain management procedures performed by a physician are **medically necessary** when *the relevant criteria are met and only one procedure is performed per visit, with radiographic guidance.*

Note: Discontinuing anticoagulation therapy or anti-platelet therapy is a clinical decision balancing risks and benefits of the procedure on therapy, versus the underlying medical condition if not treated appropriately.

I. Selective Nerve Root Blocks (SNRB)

A. Diagnostic SNRB for the evaluation and diagnostic work-up of radicular pain is considered **medically necessary** when all of the following are met:
   1. There is severe radicular pain in a specific nerve root distribution that interferes substantially with activities of daily living (ADLs);
   2. Severe pain persists after treatment with nonsteroidal anti-inflammatory drugs (NSAIDs) and/or opiate (both ≥ four weeks or contraindicated/not tolerated);
   3. One of the following:
      a. Clinical presentation does not correlate with imaging such as magnetic resonance imaging (MRI) or computed tomography (CT);
      b. Clinical findings suggest multilevel root involvement, and identification of the pain is necessary to guide treatment planning.

B. *SNRBs* are considered **not medically necessary** for any other indication not listed above because effectiveness has not been established.

II. Transforaminal Epidural Steroid Injections (TFESI)

A. *One TFESI for acute* pain management (pain lasting < three months) is considered **medically necessary** when all of the following are met:
   1. There is severe radicular pain in a specific nerve root distribution that interferes substantially with ADLs;
   2. Severe pain persists after treatment with NSAID and/or opiate (both ≥ four weeks or contraindicated/not tolerated);
   3. Cannot tolerate chiropractic or physical therapy, and the injection is intended as a bridge to therapy.

B. *One TFESI for chronic pain* is considered **medically necessary** when all of the following are met:
   1. TFESI is requested for a single level bilaterally or up to two levels unilaterally;
   2. There is persistent radicular pain caused by disc herniation in a defined nerve root level, or spinal stenosis confirmed by physical exam and imaging;
   3. Pain interferes with ADLs and has lasted for at least three months;
   4. Failure to respond to conservative therapy including all of the following:
      a. ≥ four weeks chiropractic, physical therapy or prescribed home exercise program;
      b. NSAID ≥ four weeks or NSAID contraindicated or not tolerated;
      c. ≥ four weeks activity modification.

C. *A second TFESI for chronic pain* that **did not** improve from the initial injection is considered **medically necessary** when meeting all of the following:
   1. Request is for a TFESI at one level bilaterally or up to two levels unilaterally;
   2. At least two weeks have passed since the first TFESI;

D. *Subsequent TFESIs for recurrence of chronic pain* that **had improved** from the first or second TFESI are considered **medically necessary** with all of the following:
   1. The TFESI is requested at a single level bilaterally or up to two levels unilaterally;
   2. There was ≥ 50% relief and functional improvement for at least three months since the last injection;
   3. Less than four injections have been given at the same site within 12 months;
   4. Less than 12 months have elapsed since the initial injection at the level requested;

E. *Continuation of injections beyond 12 months or more than 4 therapeutic injections* will be considered on a case-by-case basis when more definitive therapies cannot be tolerated or provided based on all the following criteria:
   1. Pain is severe enough to cause a significant degree of functional disability or vocational disability and providers use established and measurable goals and objective scales to assess functionality and ADL measures ;
   2. ESI have provided at least 50% sustained and consistent improvement of pain and/or 50% sustained and consistent objective improvement in function for at least three months;
   3. Rationale for the continuation of ESIs including but not limited to one of the following:
      a. Member/enrollee is high-risk surgical candidate;
      b. Member/enrollee does not desire surgery;

c. Recurrence of pain in the same location was sustained and consistently relieved with ESIs for at least three months.

4. *TFESIs* for any other indication not listed above are considered **not medically necessary** because effectiveness has not been established.

Background

Epidural steroid injections/selective nerve root blocks

There is great controversy regarding the effectiveness of invasive interventions for spinal pain. Epidural glucocorticoid injections have been used for pain control in patients with radiculopathy, spinal stenosis, and nonspecific low back pain despite inconsistent results as well as heterogeneous populations and interventions in randomized trials. Epidural injections are performed utilizing three approaches in the lumbar spine: caudal, interlaminar, and transforaminal. Generally, candidates for epidural steroid injection are individuals who have acute radicular symptoms or neurogenic claudication unresponsive to traditional analgesics and rest, with significant impairment in activities of daily living. Epidural steroid injections have been used in the treatment of spinal stenosis for many years, and no validated long-term outcomes have been reported to substantiate their use. However, significant improvement in pain scores have been reported in short-term outcomes up to three months after injection.[2] A selective nerve root block (SNRB) is primarily used to diagnose the specific source of nerve root pain. In a SNRB, a local anesthetic is used. When used for therapeutic indications, a steroid is added, and it is usually referred to as a selective transforaminal epidural steroid injection.

A 2015 meta-analysis was conducted to assess the effects of various surgical and nonsurgical modalities, including epidural injections, used to treat lumbar disc herniation (LDH) or radiculitis.[3] A systematic literature search was conducted to identify RCTs which compared the effect of local anesthetic with or without steroids. The outcomes included pain relief, functional improvement, opioid intake, and therapeutic procedural characteristics. The reviewers concluded that the meta-analysis confirms that epidural injections of local anesthetic with or without steroids have beneficial but similar effects in the treatment of patients with chronic low back and lower extremity pain.[3]

Results of a two-year follow-up of three randomized, double-blind, controlled trials, with a total of 360 patients with chronic persistent pain of disc herniation receiving either caudal, lumbar interlaminar or transforaminal epidural injections, showed similar efficacy of the three techniques with local anesthetic alone or local anesthetic with steroid.[4] Interlaminar injections with steroids were superior to transforaminal at 12 months.[4]

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 2025, 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. 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
64479	Injection(s), anesthetic agent(s) and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level
64480	Injection(s), anesthetic agent(s) and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
64483	Injection(s), anesthetic agent(s) and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level
64484	Injection(s), anesthetic agent(s) and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)

Reviews, Revisions, and Approvals	Revision Date	Approval Date
SNRB and TFESI criteria reviewed and updated in CP.MP.118.	04/18	04/18
Annual review. References reviewed and updated. In policy statement, removed option for procedures "without radiographic guidance." Reviewed by specialist. Changed "Last Review Date" in header to "Date of Last Revision" and changed "Date" in Revision log to "Revision Date".	08/21	08/21
Annual review. Criteria updated with grammatical and abbreviation changes. Background updated with no impact on criteria. Dashes removed from code ranges. References reviewed and updated.	08/22	08/22
Annual review. ICD-10 Code table removed. Minor edits with no clinical significance. References reviewed and updated. Reviewed by internal specialist.	08/23	08/23
Annual review. In I.B.4.a. and c. and II.B.5.a. and c. changed duration from six weeks to four weeks. Added Table 1 to give examples of particulate and non-particulate steroids. References reviewed and updated. Reviewed by external specialist.	07/24	07/24
Annual review. Added note in Description regarding policy for caudal or interlaminar epidural steroid injections. Removed anticoagulation therapy requirement in Criteria and added anticoagulation therapy as a note in Criteria. Updated Criteria II.D.3. from two months to three months regarding relief and functional improvement. Removed Criteria II.D.4. regarding length of time since last transforaminal epidural steroid injection (TFESI). Coding and descriptions reviewed. References reviewed and updated. Reviewed by internal specialist.	07/25	07/25
Annual review. Revised Section I. Selective Nerve Root Blocks to reflect criteria for diagnostic purposes only and removed all therapeutic indications for SNRB from policy. Under I.A.2. replaced	07/26	07/26

Reviews, Revisions, and Approvals	Revision Date	Approval Date
"three days" with "four weeks". Under. I.A.3.a added new criteria "Clinical presentation does not correlate…". Under I.A.3.b. added new criteria "Clinical findings suggest…" Under I.B. added "not listed above". Under II.A.2. removed "If a cervical TFESI…". Under II.A.3. replaced "three days" with "four weeks". Under. II.B.2. removed "If a cervical TFESI…". Under II.B.5. replaced "three" with "four". Under II.C.2. removed "If a cervical TFESI…". Under II.D.2. removed "If a cervical TFESI…". Reworded section II.E. and added new criteria II.E.1-II.E.4. Under II.F. added "not listed above". Removed Table 1: Particulate and Non-Particulate Steroids. References reviewed and updated. Reviewed by internal and external specialists.		

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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. The Health Plan 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. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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