PROVIDER NOTIFICATION OF POLICY CRITERIA CHANGE					
POLICY TITLE	**POLICY NUMBER**	**CRITERIA CHANGE**	**MATERIAL AMENDEMENT**	**EFFECTIVE DATE**	**LINK TO FULL POLICY**
Transplant, Liver	1998104	Rationale and references updated. Policy/coverage statement reformatted for clarification. Restricted coverage added for unresectable colorectal liver metastases.	No	01/01/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=1998104
Epidural Steroid Injections for Back Pain	2025012	Policy/coverage statement reformatted and updated for clarification: **Meets Primary Coverage Criteria Or Is Covered For Contracts Without Primary Coverage Criteria** The use of spinal epidural steroid injections (ESI) with image guidance (fluoroscopy or CT) meets member benefit certificate Primary Coverage Criteria that there be scientific evidence of effectiveness as part of a comprehensive pain management plan when **ALL** of the following criteria are met: 1. Pain is radicular or referred, with a duration of at least 4 weeks; 2. Pain is persistent and of at least moderate-to-severe intensity (VAS Pain Scale score of at least 5 or ODI score of moderate disability or worse). The SAME scale must be used at each follow-up for assessment of response; 3. Pain has failed to respond to 4 weeks of conservative, noninvasive care (see definition in Policy Guidelines) OR there is documentation of why the individual could not tolerate noninvasive care; 4. Either one or both of the following: a. Objective findings of radiculopathy or a referred pain pattern are present and documented on exam (see Policy Guidelines) b. Advanced imaging (CT or MRI) findings correlate with the individual's symptoms (e.g. post-surgery syndrome or disc herniation, severe degenerative disc	No	01/01/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2025012

		disease, osteophytes producing spinal/foraminal stenosis/root compression) **<u>Frequency of ESI</u>** <u>For ESI sessions meeting the criteria outlined above:</u> * ESIs are limited to a maximum of four (4) sessions per spinal region in a rolling twelve (12) month period, regardless of the number of levels. * No more than 2 TFESIs should be performed at a single setting (e.g. single level bilaterally or two levels unilaterally). * Interlaminar ESIs and caudal ESIs involve a maximum of one vertebral level and one side. * No more than one spinal region is to be injected in a single ESI session. * If initial ESI is unsuccessful, a repeat ESI after 14 days can be performed using a different approach, vertebral level and/or medication, if appropriate, with the rationale and medical necessity for the second ESI documented in the medical record. * Repeat ESI at the same vertebral level with the same technique, when the first injection directly and significantly provided improvement of the condition being treated, meets member benefit certificate Primary Coverage Criteria that there be scientific evidence of effectiveness when the medical record documents at least 50% sustained improvement in pain relief AND improvement in function, measured from baseline using SAME scale, for at least three months. ******* There are clinical circumstances where it may be medically appropriate to perform additional injections for a specific episode of radicular pain that exceeds the total number allowed **OR** for a clinical indication that does not meet all the criteria listed			

		above. An Organizational Determination/Benefit Inquiry request may be submitted with documentation to support the medical necessity followed by a Peer to Peer conversation for consideration of an exception to the policy. *** **[**These circumstances include: Performance of selective nerve root blocks (SNRBs) for surgical planning after failed ESIs; the presence of new injuries after resolution of a prior condition or after interval surgery since prior ESIs; prior injections were done without fluoroscopy or were inaccurately placed; exacerbation of symptoms that responded well to prior ESIs; and patients who responded well to prior ESIs that are not surgical candidates due to comorbid medical conditions.**]** **Policy Guidelines:** * An initial injection of contrast is required to confirm epidural placement, unless the patient has a contraindication to contrast. The subsequent ESI should include corticosteroids and may be combined with anesthetics or saline. * Films that adequately document final needle position and injectate flow must be retained in the medical record and made available upon request. * Coverage is limited to one type of block or pain management procedure per date of service and monitored anesthesia is not covered. Conservative noninvasive therapy for at least 4 weeks should include the following: • Use of prescription-strength analgesics for several weeks at a dose sufficient to induce a therapeutic response with or without nerve membrane stabilizers or muscle relaxants; • Participation in at least 4 weeks of physical therapy or chiropractic care or physician-directed home exercise program R**adiculopathy**			

		Radiculopathy is a subset of back pain that is associated with irritation of 1 or more spinal nerve roots. Symptoms of lumbar radiculopathy include pain that radiates down the leg to below the knee, numbness, muscle weakness, and lack of reflexes in a dermatomal distribution (Pinto, 2012). Radiculopathy is defined as pain that is distributed along a specific nerve root or specified dermatomal distribution with corresponding sensory changes, muscle weakness, and diminished reflexes. **<u>Objective findings for radicular pain:</u>** • Sensory loss in a specific dermatome; • Motor weakness in a specific myotome; • Reduced or absent deep tendon reflexes; • Physical exam confirmatory tests: Spurling test for the neck; straight leg raise test for the back; EMG/NCVs **VAS Pain Scale:** **0** – No Pain **Mild Pain –** Doesn't interfere with daily living activities. **1** – Pain is very mild, barely noticeable. Most of the time individual doesn't think about the pain. **2** – Minor pain. Annoying and may result in occasional sharp pains or twinges. **3** – Pain is noticeable and distracting, but individual can get used to it and adapt. **Moderate Pain –** Interferes with daily living activities. **4** – Moderate pain. If deeply involved in an activity, the pain can be ignored for a period of time but is still distracting. **5** – Moderately strong pain. It can only be ignored for a few minutes, but with effort individual can still manage to work or participate in some social activities. **6** – Moderately strong pain that interferes with normal daily activities. Difficulty concentrating. **Severe Pain –** Unable to perform daily living activities. **7** – Severe pain that significantly limits the individual's ability to perform normal daily activities or maintain social relationships. Interferes with sleep.			

		8 – Very strong pain. Physical activity is severely limited. Conversing requires great effort. **9** – Excruciating pain. Pain very hard to tolerate Unable to carry on a conversation. Could result in crying out and/or moaning uncontrollably. **10** – Worst pain possible. **<u>Interpretation of the ODI score</u>** 1. 0 – 20%: mild disability. 2. 20 – 40%: moderate disability. 3. 40 – 60%: severe disability. 4. 60 – 80%: disabling. 5. 80 – 100%: bedridden or functional impairment **<u>Does Not Meet Primary Coverage Criteria Or Is Not Covered For Contracts Without Primary Coverage Criteria</u>** The use of ESI for any condition not described above, including but not limited to, nonspecific low back pain, axial/non-radicular spine pain, complex regional pain syndrome, widespread diffuse pain, pain from neuropathy from other causes, cervicogenic headaches, or any neck/back pain not meeting the above criteria does not meet member benefit certificate Primary Coverage Criteria that there be scientific evidence of effectiveness. For members with contracts without Primary Coverage Criteria, the use of ESI for any condition not described above including but not limited to nonspecific low back pain, axial/non-radicular spine pain, complex regional pain syndrome, widespread diffuse pain, pain from neuropathy from other causes, cervicogenic headaches, or any neck/back pain not meeting the above criteria is considered Not Medically Necessary or is investigational and is not covered. Investigational services are specific contract exclusions in most member benefit certificates of coverage. Additional ESIs performed with the same technique at the same vertebral level, less than 30 days apart, do not meet member benefit certificate Primary Coverage Criteria that there be scientific evidence			

		of effectiveness for all spinal regions (cervical, thoracic, or lumbar), For members with contracts without Primary Coverage Criteria, additional ESI performed with the same technique at the same vertebral level, less than 30 days apart, are considered Not Medically Necessary or is investigational and is not covered for all spinal regions (cervical, thoracic, or lumbar). Investigational services are specific contract exclusions in most member benefit certificates of coverage. ESI sessions exceeding 4 per 12-month period do not meet member benefit certificate Primary Coverage Criteria that there be scientific evidence of effectiveness. For members with contracts without Primary Coverage Criteria, ESI sessions exceeding 4 per 12-month period are considered Not Medically Necessary or is investigational and is not covered. Investigational services are specific contract exclusions in most member benefit certificates of coverage. The use of ultrasound guidance, fluorography (imaging of the epidural space) with ESI does not meet member benefit certificate Primary Coverage Criteria that there be scientific evidence of effectiveness. For members with contracts without Primary Coverage Criteria, the use of ultrasound guidance, fluorography (imaging of the epidural space) with ESI is considered Not Medically Necessary or is investigational and is not covered. Investigational services are specific contract exclusions in most member benefit certificates of coverage.			
Medical Technology Assessment, Non-Covered Services	2022013	E1033 and E1034 will be removed from policy effective 12/15/2025. The coverage status of E1033 and E1034 will be changed from non-covered to restricted coverage.	No	12/15/2025	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2022013

Ultrafiltration in Decompensated Heart Failure	2006038	Policy will be archived effective December 15, 2025	No	12/15/2025	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2006038