1. **Purpose**
   The purpose of this policy is to establish the criteria when the use of epidurography is considered medically necessary.

2. **Definitions**
   Epidurography is defined as a radiologic imaging examination performed on the veins lining the spinal canal. Contrast is injected into the epidural space under direct fluoroscopy. Examining the flow of contrast in the epidural space around the nerves to be studied, aids in the diagnosis of intervertebral disc herniation, narrowing and swelling around the nerve and/or nerve roots, and compressive lesions.

3. **Statement of Policy**
   3.1. Radiological supervision with epidurography and fluoroscopy **may be considered medically necessary** when any of the following have been met:
   - The surgeon documents prior to the procedure the necessity of epidurography to identify anatomic or functional abnormalities not identified with other imaging studies such as MRI, CT scan or CT scan following myelography; or
   - The patient has continuous epidural infusion via catheter; and
     - Initial assessment to determine epidural infusion rate is necessary; or
     - The epidurogram is necessary to diagnose failure of a previously functional catheter infusion.
   
   3.2. When epidurogram is performed, the following documentation is required:
   - A preoperative note defining the surgical or clinical requirement of this procedure versus fluoroscopy; and
   - A separate procedural note containing the following:
     - Detailed description of the bony anatomy of the spinal canal in the area where the epidurogram was performed; and
     - Detailed description of the extent of spread of contrast within the epidural space, using reference in the anteroposterior and coronal axes; and
4. References

4.1. Scientific:

The following scientific references were utilized in the formulation of this medical policy. Triad Healthcare, Inc. will continue to review clinical evidence surrounding Epidurography and may modify this policy at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to Triad Healthcare, Inc. so the information can be reviewed by the Academic Advisory Committee (AAC) and the Medical Quality Improvement Committee (MQIC) to determine if a modification of the policy is in order.

- Du Pen SL. Epidurogram in the management of patients with long-term epidural catheters. Reg Anesth 21(1)61-7 01-Jan-1996

4.2. Related Triad Medical Policies:

- TMMP 18 – Medical Necessity

CPT Codes

This policy relates to the use of the following CPT Codes:

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description (AMA CPT Guide)</th>
</tr>
</thead>
<tbody>
<tr>
<td>72275</td>
<td>Epidurography, radiological supervision and interpretation.</td>
</tr>
<tr>
<td>77003</td>
<td>Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedure (epidural or</td>
</tr>
</tbody>
</table>
CPT Codes | Description (AMA CPT Guide)
--- | ---
 | subarachnoid).

This list may not be all inclusive and is not intended to be used for coding/billing purposes.

**Table of Revisions**

<table>
<thead>
<tr>
<th>Revision Date</th>
<th>Modified By</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/24/2014</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. No changes. Document Control number revised from PRV.MQ.MP.052.001 to PRV.MQ.MP.058.001 due to duplicate assignment. Reformatting completed.</td>
</tr>
<tr>
<td>03/03/2013</td>
<td>Level 1, 2, 3</td>
<td>New medical policy.</td>
</tr>
</tbody>
</table>

Triad’s Medical Policies are not recommendations for treatment and providers are expected to exercise their clinical judgment in providing the most appropriate care. Health care providers and patients should not rely on these Medical Policies in making health care decisions. These Medical Policies are guidelines and do not constitute an authorization, certification, explanation of benefits or guarantee of payment. Applications of Triad’s Medical Policies are determined by the enrollee’s benefit documents and contracts and as such individual benefits must be verified. Determinations of medical necessity apply only if the benefit exists and no contract exclusions are applicable. In the event of a conflict, a participant’s benefit plan document shall supersede the information contained in Triad’s Medical Policies.