

CODING SPOTLIGHT FEATURE

Coding Spotlight Feature: Epidural Steroid Injections

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Epidural steroid injections (ESIs) are frequently included in Medical Cost Projections and Life Care Plans, yet vague documentation can lead to coding ambiguity and unreliable cost estimates. This column outlines a structured, code-neutral approach to improving accuracy in procedural identification and cost modeling by emphasizing key elements such as injection approach, spinal region, imaging use, levels treated, therapeutic agents, and place of service. It highlights the importance of aligning clinical documentation with procedural specificity and reinforces the role of collaboration with treating providers to ensure defensible and consistent projections. By standardizing how ESIs are documented and interpreted, practitioners can enhance the credibility and reliability of projected care costs.

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Feature: Epidural Steroid Injections

Epidural steroid injections (ESIs) remain one of the most frequently projected procedures in Medical Cost Projections (MCPs) and Life Care Plans (LCPs). However, nonspecific documentation, such as simply noting “ESI”, can result in coding ambiguity, inaccurate cost assignments, and weakened defensibility in litigation or settlement contexts. This column provides a practical, code-neutral approach to identifying the correct procedural pathway, improving cost consistency, and strengthening the overall reliability of projected care estimates.

Step 1: Identify the Approach

Accurate reporting begins with defining the approach: transforaminal or interlaminar (which includes a caudal route). Each approach corresponds to a unique set of procedural categories, and this distinction must be clear in both clinical documentation and cost modeling.

After defining the approach, specify the spinal region involved: cervical, thoracic, lumbar, or sacral. Together, the route and region determine the correct code family and the corresponding reimbursement range (American Medical Association, 2024).

Step 2: Determine Imaging Use and Levels

For interlaminar injections

Indicate whether imaging guidance (fluoroscopy, CT, or ultrasound) is used. Some procedural categories incorporate imaging by definition, while others differentiate between services performed “*with*” versus “*without*” it. Imaging inclusion influences both procedural selection and valuation.

For transforaminal injections

Document laterality (unilateral or bilateral) and the number of spinal levels treated. When injections are performed on both sides of the same vertebral interspace, bilateral reporting rules apply, typically warranting a 150% pricing adjustment to reflect the additional work.

For multiple levels, add-on logic applies for each additional interspace treated.

Step 3: Identify the Injected Agents

Detail the therapeutic agent(s) administered; whether anesthetic, corticosteroid, opioid, or antispasmodic. Local anesthetics such as lidocaine or bupivacaine are generally considered integral to the service, but therapeutic or neurolytic agents (e.g., dexamethasone or morphine sulfate) may require separate cost consideration when itemizing projected care.

Step 4: Consider the Place of Service

The site of service (office, ambulatory surgery center, or hospital outpatient department) has a direct impact on reimbursement. Office-based procedures typically yield lower reimbursement due to bundled overhead, whereas

hospital-based procedures incorporate higher facility costs into their fee structures. When modeling cost projections, ensure that the setting used reflects the clinical reality of where the service is expected to occur.

Final notes

Equally important, remember that treating providers are the ultimate source of procedural specificity. They possess the clinical knowledge of laterality, targeted levels, approach, and drug selection; information that may not always be fully reflected in summarized records.

Obtaining these details can occur directly through peer-to-peer discussions or indirectly through a thorough review of prior operative or procedure notes when the patient has undergone the intervention in the past. Integrating this collaborative verification step ensures that the projected codes and costs truly mirror clinical reality.

Key Takeaway

Accuracy in coding and cost modeling depends on clear clinical documentation. To ensure defensible medical cost projections:

- Define the approach and spinal region
- Specify laterality, number of levels, and imaging use
- Include the therapeutic agent administered
- Confirm the place of service
- Collaborate with the treating providers to validate procedural details

Accurate documentation leads to accurate coding, and accurate coding supports credible, defensible costs of care.

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Author Note

This column is intended for educational and informational purposes only. The content is based on coding principles and procedural reporting standards established by the American Medical Association (AMA) and other recognized regulatory sources. Procedural codes that correspond to the services described are part of the Current Procedural Terminology (CPT®) code set, which is copyright © American Medical Association. These specific code numbers are not reproduced or displayed in this publication to maintain compliance with AMA copyright and licensing requirements.

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