

1 **Clinical Practice Guideline: Intralesional Injections of the Ankle and Foot**

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3 **Date of Implementation: December 18, 2015**

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5 **Product: Specialty**

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8 **GUIDELINES**

9 American Specialty Health – Specialty (ASH) considers services consisting of CPT Codes
10 11900 and 11901 to be medically necessary for the following indications:

- 11 • Acute and chronic inflammatory processes of the skin, OR
12 • Recalcitrant plantar warts (verrucae), OR
13 • Hyperplastic and hypertrophic skin disorders, OR
14 • Skin lesions whose systemic underlying condition responds favorably to systemic
15 corticosteroids, and for which intralesional deposition of medication is required for
16 an improved local effect

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18 **CPT CODES AND DESCRIPTIONS**

CPT®Code	CPT®Code Description
11900	Injection, intralesional; up to and including 7 lesions
11901	Injection, intralesional; more than 7 lesions

19
20 **BACKGROUND**

21 The direct delivery of medication percutaneously into skin lesions, intralesional injection,
22 is relatively safe and effective for a wide range of indications. The drugs primarily used for
23 intralesional injections are corticosteroids. The standard injectable steroid is triamcinolone
24 acetamide (Kenalog) (Richards, 2010). Although bleomycin, 5-fluorouracil, methotrexate,
25 chloroquine, and interferons are gaining wider use for intralesional therapy, the scope of
26 this clinical practice guideline is limited to the use of intralesional corticosteroids.

27
28 The purpose of intralesional therapy is to deliver a medication directly into a specific skin
29 lesion to treat local tissues with minimal systemic effects. The skin also serves as a
30 reservoir, allowing medication deposited in the dermis to be delivered over a period of
31 time, resulting in prolonged therapy while avoiding or minimizing the adverse effects of
32 systemic therapy.

33
34 Indications for intralesional corticosteroid therapy are acute and chronic inflammatory
35 processes, and hyperplastic and hypertrophic skin disorders such as keloids, lichen simplex
36 chronicus, hypertrophic lupus, and psoriasis.

1 Intralesional injections are not recommended when the possibility of infection is present,
2 either as the etiology of the lesion or as a secondary sequela. Although intralesional
3 corticosteroids have the ability to produce systemic effects, occurrence of these effects is
4 rare. These effects typically are seen when large amounts of corticosteroids or frequent
5 injections are administered to patients but can occur in smaller doses in diabetic patients.
6

7 The most common side effects of intralesional corticosteroid injections are local. These
8 include atrophy and hypopigmentation. Rarely, a sterile abscess may form at the site of
9 the injection. Atrophy and pigment changes usually resolve over several weeks but
10 occasionally persist longer and are sometimes permanent. Darkly pigmented skin is most
11 susceptible to hypopigmentation and depigmentation; therefore, caution should be used
12 when injecting these patients and the patients should be advised of this potential
13 complication.
14

15 Complications related to intralesional injections typically can be avoided by using the
16 lowest concentration and smallest quantity of drug needed to achieve the desired results. It
17 is preferable to inject corticosteroids in small amounts and low concentrations and have to
18 repeat the injection in three to four weeks than to overestimate the corticosteroid dose and
19 suffer a complication. Patients should be advised that the first treatment may not be
20 completely effective, and more than one injection may be necessary.
21

22 **PRACTITIONER SCOPE AND TRAINING**

23 Practitioners should practice only in the areas in which they are competent based on their
24 education, training and experience. Levels of education, experience, and proficiency may
25 vary among individual practitioners. It is ethically and legally incumbent on a practitioner
26 to determine where they have the knowledge and skills necessary to perform such services
27 and whether the services are within their scope of practice.
28

29 It is best practice for the practitioner to appropriately render services to a member only if
30 they are trained, equally skilled, and adequately competent to deliver a service compared
31 to others trained to perform the same procedure. If the service would be most competently
32 delivered by another health care practitioner who has more skill and training, it would be
33 best practice to refer the member to the more expert practitioner.
34

35 Best practice can be defined as a clinical, scientific, or professional technique, method, or
36 process that is typically evidence-based and consensus driven and is recognized by a
37 majority of professionals in a particular field as more effective at delivering a particular
38 outcome than any other practice (Joint Commission International Accreditation Standards
39 for Hospitals, 2020).
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41 Depending on the practitioner's scope of practice, training, and experience, a member's
42 condition and/or symptoms during examination or the course of treatment may indicate the

1 need for referral to another practitioner or even emergency care. In such cases it is prudent
 2 for the practitioner to refer the member for appropriate co-management (e.g., to their
 3 primary care physician) or if immediate emergency care is warranted, to contact 911 as
 4 appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* policy for
 5 information.

6 7 **References**

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