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

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

Product: **Specialty**

GUIDELINES

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

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

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

DESCRIPTION/BACKGROUND

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

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

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

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

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

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

PRACTITIONER SCOPE AND TRAINING

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

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

Best practice can be defined as a clinical, scientific, or professional technique, method, or process that is typically evidence-based and consensus driven and is recognized by a majority of professionals in a particular field as more effective at delivering a particular outcome than any other practice (Joint Commission International Accreditation Standards for Hospitals, 2020).

Depending on the practitioner's scope of practice, training, and experience, a member's condition and/or symptoms during examination or the course of treatment may indicate the need for referral to another practitioner or even emergency care. In such cases it is prudent for the practitioner to refer the member for appropriate co-management (e.g., to their primary care physician) or if immediate emergency care is warranted, to contact 911 as appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* policy for information.

References

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