

MEDICAL POLICY

Medical Policy Title	Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members
Policy Number	7.01.122
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Our medical policies are guides to evaluate technologies or services for medical necessity. Criteria are established through the assessment of evidence based, peer-reviewed scientific literature, and national professional guidelines. Federal and state law(s), regulatory mandates and the member's subscriber contract language are considered first in the determination of a covered service.

(Link to [Product Disclaimer](#))

SECTION LINKS

Epidural Steroid Injection (ESI)

- [Initial](#)
- [Repeat](#)

Selective Nerve Root Block (SNRB)

- [Diagnostic](#)

Facet Joint Injection/ Medial Branch Blocks

- [Initial](#)
- [Repeat](#)
- [Alternative to Radiofrequency Ablation/Neurotomy](#)

Radiofrequency neurolysis (denervation/ablation)

- [Initial](#)
- [Repeat](#)

Sacroiliac Joint Injection

- [Diagnostic](#)
- [Therapeutic](#)
- [Repeat](#)

POLICY STATEMENT(S)

Initial Epidural Steroid Injection (ESI)

- I. An initial ESI (caudal, interlaminar, or transforaminal) is considered **medically appropriate** when documentation meets **ALL** the following:
 - A. The individual is diagnosed with **ANY** of the following:
 1. Degenerative lumbar spondylolisthesis with neurological findings and/or deficits (e.g., back pain, leg pain, motor weakness);

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 2 of 29

2. Failed back surgery syndrome (FBSS) or epidural fibrosis; **or**
3. Spinal stenosis (foraminal, central, or disc disease);
- B. Pain-related symptoms meet **all** the following:
 1. Radicular pain, acute or chronic, with or without motor weakness;
 2. Pain causes a functional impairment;
 3. A minimum of 6 weeks of conservative management during the previous 6 months failed, or was not tolerated, and includes **BOTH** of the following:
 - a. Non-pharmacologic management with **either**:
 - i. Chiropractic care; **or**
 - ii. Supervised physical therapy (PT); **and**
 - b. Pharmacological management with **either**:
 - i. Medication directed at the underlying disease process; **or**
 - ii. Oral analgesics;
- II. An initial ESI is considered **not medically necessary** for **ANY** of the following contraindications:
 - A. Allergy or hypersensitivity to any component of the injectate;
 - B. Local infection at the planned injection;
 - C. Systemic infection;
 - D. Infectious spondylosis;
 - E. Uncontrolled bleeding or clotting disorder;
 - F. Malignancy involving the planned injection site;
 - G. Pregnancy; **or**
 - H. Refusal of the procedure by the individual or legally authorized representative;
 - I. ESI will be performed under computed tomography (CT) or fluoroscopic guidance.

Repeat ESI

- III. A repeat ESI (caudal, interlaminar, or transforaminal) is considered **medically appropriate** when documentation meets **ALL** the following:
 - A. Active engagement in non-surgical conservative management with chiropractic care or supervised PT, unless intolerance due to pain is documented;
 - B. Pain and/or functional impairment persist;
 - C. Performed for **either** of the following scenarios:

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 3 of 29

1. For diagnostic injections(s), with/without steroids, when **both** of the following are met:
 - a. No more than two (2) injections in total have been performed; **and**
 - b. It has been at least 2 weeks between injections; **or**
2. For therapeutic injections, when **all** the following are met:
 - a. No more than four (4) injections have been performed per year, per spinal region;
 - b. It has been at least 10 weeks between injections;
 - c. A minimum of 50% reduction in pain was a result of the previous injection; **and**
 - d. Pain relief lasted for a minimum of 10 weeks.

IV. A repeat ESI is considered **not medically necessary** for **ANY** of the following contraindications:

- A. Allergy or hypersensitivity to any component of the injectate;
- B. Local infection at the planned injection site;
- C. Systemic infection;
- D. Infectious spondylosis;
- E. Uncontrolled bleeding or clotting disorder;
- F. Malignancy involving the planned injection site;
- G. Pregnancy; **or**
- H. Refusal of the procedure by the individual or legally authorized representative.

Selective Nerve Root Block (SNRB)

V. A diagnostic selective nerve root block (SNRB) is considered **medically appropriate** when documentation meets **ALL** the following:

- A. Performed at one (1) or more spinal levels;
- B. Anesthetic injectate only is used;
- C. Performed to assist in establishing a diagnosis of radicular pain (e.g., radiculitis, radiculopathy) when there is no known pain diagnosis;
- D. Completed diagnostic evaluation includes **one (1) or more** of the following:
 1. Neurological examination;
 2. Electrodiagnostic testing; **or**
 3. Relevant imaging studies;
- E. Documentation of **either** of the following:
 1. Clinical findings are suggestive of nerve root pathology; **or**

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 4 of 29

2. Performed for preoperative planning.

VI. SNRB is considered **not medically necessary** for **ANY** of the following contraindications:

- A. Allergy or hypersensitivity to any component of the injectate;
- B. Local infection at the planned injection;
- C. Systemic infection;
- D. Infectious spondylosis;
- E. Uncontrolled bleeding or clotting disorder;
- F. Malignancy involving the planned injection site;
- G. Pregnancy; **or**
- H. Refusal of the procedure by the individual or legally authorized representative.

Initial Facet Joint Injections (FJI) and/or Medial Branch Blocks (MBB)

VII. An initial FJI (cervical, thoracic or lumbar) or MBB are considered **medically appropriate** when the documentation meets **ALL** the following:

- A. Pain-related symptoms meet **all** the following:
 1. Persistent for a minimum of 12 weeks;
 2. Pain causes a functional impairment;
 3. Non-radicular (cervical, thoracic or lumbar);
- B. A minimum of 6 weeks of conservative management, unless contraindicated, during the previous 6 months failed or was not tolerated, including **both** of the following:
 1. Non-pharmacologic management with **either**:
 - a. chiropractic care; **or**
 - b. supervised physical therapy (PT); **and**
 2. Pharmacological management with **either**:
 - a. Medication directed at the underlying disease process; **or**
 - b. Oral analgesics;
- C. The procedure will be performed under computed tomography (CT) or fluoroscopic guidance.

VIII. An initial FJI or MBB is considered **not medically necessary** for **ANY** of the following contraindications:

- A. Allergy to any component of the injectate;
- B. Uncontrolled bleeding or clotting disorder;

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 5 of 29

- C. Active infection;
- D. Pregnancy when ultrasound guidance is not available; **or**
- E. History of spinal fusion at the same level.

Repeat FJI/MBB

IX. A repeat FJI or MBB are considered **medically appropriate** when the documentation meets **ALL** the following:

- A. Performed at the same level as the initial block;
- B. Performed for **either** of the following scenarios:
 - 1. For diagnostic injections(s) when **all** the following are met:
 - a. No more than two (2) injections per region;
 - b. A minimum of 70% reduction in pain was a result of the initial injection;
 - c. A minimum of 6 weeks of conservative management during the previous 6 months failed or was not tolerated, including **BOTH** the following:
 - i. Non-pharmacologic management with **either**:
 - a) chiropractic care; **or**
 - b) supervised physical therapy (PT); **and**
 - ii. Pharmacological management with **either**:
 - c) Medication directed at the underlying disease process; **or**
 - d) Oral analgesics;
 - 2. For therapeutic injections, when **all** the following are met:
 - a. No more than three (3) injections per region performed in a 12-month period;
 - b. A minimum of 50% pain relief from the prior injection;
 - c. Pain relief lasted for a minimum of 3 months; and
 - d. Active engagement in non-surgical conservative management with chiropractic care or supervised PT, unless intolerance due to pain is documented;

X. A repeat FJI or MBB is considered **not medically necessary** for **ANY** of the following contraindications:

- A. Allergy to any component of the injectate;
- B. Uncontrolled bleeding or clotting disorder;
- C. Active infection;
- D. Pregnancy when ultrasound guidance is not available; **or**

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 6 of 29

- E. History of spinal fusion at the same level.

FIJ/MSS as an Alternative to Radiofrequency Ablation/Neurotomy

XI. FIJ/MBB as an alternative to radiofrequency ablation/neurotomy is considered **medically appropriate** when documentation meets **ALL** of the following:

- A. Significant pain relief (e.g., greater than 50%) was a result of the initial FIJ/MBB;
- B. Pain relief lasted a minimum of 12 weeks;
- C. Radiofrequency denervation/ablation is not appropriate due to **ANY** of the following:
 - 1. Implanted cardiac device (e.g., pacemaker, defibrillator);
 - 2. Prior diagnostic injection positive outcomes support continued injection-based therapy;
 - 3. Continued anticoagulation therapy is required; **or**
 - 4. Young athletes for whom alternative treatment options are preferred based on long-term considerations;

XII. FIJ/MBB as an alternative to radiofrequency ablation/neurotomy is considered **not medically necessary** for **ANY** of the following contraindications:

- A. Allergy to any component of the injectate;
- B. Uncontrolled bleeding or clotting disorder;
- C. Active infection;
- D. Pregnancy when ultrasound guidance is not available; **or**
- E. History of spinal fusion at the same level.

Initial Radiofrequency Neurolysis, Paravertebral Facet Joint/Medial Branch Transection

XIII. Initial radiofrequency neurolysis (denervation/ablation) of a paravertebral facet joint or medial branch transection is considered **medically appropriate** when the documentation meets **ALL** the following:

- A. There is no evidence from the clinical assessment, diagnostic evaluation, or imaging studies of an alternative pain generator (e.g., central spinal stenosis, foraminal stenosis, disc herniation, fracture, infection, spinal instrumentation, pseudoarthrosis, or neoplastic disease);
- B. Pain-related symptoms meet **all** the following:
 - 1. Persistent for a minimum of 3 months;
 - 2. Pain causes a functional impairment;
 - 3. A minimum of 6 weeks of conservative management during the previous 6 months failed or was not tolerated, including **ALL** of the following:

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 7 of 29

- a. Non-pharmacologic management with **either**:
 - i. chiropractic care; **or**
 - ii. supervised physical therapy (PT); **and**
 - b. Pharmacological management with **either**:
 - i. Medication directed at the underlying disease process; **or**
 - ii. Oral analgesics;
 - C. No more than two (2) diagnostic facet joint injections/medial branch blocks have been performed;
 - D. Previous diagnostic facet joint injections/medial branch blocks provided significant reduction in pain or functional improvement for at least the expected duration of the anesthetic utilized; The procedure will be performed under computed tomography (CT), fluoroscopic, or ultrasound guidance.
- XIV. Initial radiofrequency neurolysis (denervation/ablation) of a paravertebral facet joint or medial branch transection is considered **not medically necessary** for **ANY** of the following contraindications:
- A. Active infection;
 - B. Coagulopathy;
 - C. Myopathy, acquired or congenital;
 - D. Neuromuscular disease, including but not limited to amyotrophic lateral sclerosis (ALS);
 - E. Pregnancy; **or**
 - F. Previous spinal fusion at the same level.

Repeat Radiofrequency Neurolysis, Paravertebral Facet Joint/Medial Branch Transection

- XV. Repeat radiofrequency joint neurolysis/medial branch transection (denervation/ablations) is considered **medically appropriate** when documentation meets **ALL** the following:
- A. No more than two (2) procedures per spinal region during a 12-month period;
 - B. At least 6 months since the previous denervation/ablation at the same level;
 - C. Recurrence of pain after previously successful denervation/ablation;
 - D. Active engagement in non-surgical conservative management with chiropractic care or supervised physical therapy, unless intolerance due to pain is documented.
- XVI. Repeat radiofrequency joint neurolysis/medial branch transection (denervation/ablations) is considered **not medically necessary** for **ANY** of the following contraindications:
- A. Active infection;

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 8 of 29

- B. Coagulopathy;
- C. Myopathy, acquired or congenital;
- D. Neuromuscular disease, including but not limited to amyotrophic lateral sclerosis (ALS);
- E. Pregnancy; **or**
- F. Previous spinal fusion at the same level.

Sacroiliac Joint Injection - Diagnostic

XVII. A diagnostic sacroiliac joint injection is considered **medically appropriate** when documentation meets **ALL** of the following:

- A. At least one (1) sacroiliac provocative test is positive;
- B. Pain-related symptoms meet **ALL** the following:
 - 1. Unilateral non-radicular pain localized over the sacroiliac joint below the L5 level;
 - 2. Persistent for a minimum of 3 months;
 - 3. A minimum of 6 weeks of conservative management, unless contraindicated, during the previous 6 months failed, including **both** of the following:
 - a. Non-pharmacologic management with **either**:
 - i. chiropractic care; **or**
 - ii. supervised physical therapy (PT); **and**
 - b. Pharmacological management includes **either**:
 - i. Medication directed at the underlying disease process; or
 - ii. Oral analgesics;
- C. Injection will be performed under computed tomography (CT) or fluoroscopic guidance.

XVIII. A diagnostic sacroiliac joint injection is considered **not medically necessary** for **ANY** of the following contraindications:

- A. Allergy to any component of the injectate;
- B. Uncontrolled bleeding or clotting disorder;
- C. Active infection; **or**
- D. Pregnancy.

Sacroiliac Joint Injection - Therapeutic

XIX. A therapeutic sacroiliac injection for sacroiliac joint pain is considered **medically appropriate** when documentation meets **ALL** the following:

- A. A minimum of 50% reduction in pain was a result of the diagnostic injection;

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 9 of 29

- B. Active engagement in non-surgical conservative management with chiropractic care or supervised PT, unless intolerance due to pain is documented;
 - C. Pain causes a functional impairment.
- XX. A therapeutic sacroiliac injection for sacroiliac joint pain is considered **not medically necessary** for **ANY** of the following contraindications:
- A. Allergy to any component of the injectate;
 - B. Uncontrolled bleeding or clotting disorder;
 - C. Active infection; **or**
 - D. Pregnancy.

Sacroiliac Joint Injection - Repeat

- XXI. Repeat sacroiliac injection(s) are considered **medically appropriate** when documentation meets **ALL** of the following:
- A. Active engagement in non-surgical conservative management with chiropractic care or supervised PT, unless intolerance due to pain is documented;
 - B. Injection(s) will be performed under computed tomography (CT) or fluoroscopic guidance;
 - C. Performed for **either** of the following scenarios:
 - 1. For diagnostic injections(s) when **both** the following are met:
 - a. No more than two (2) injections per region; **and**
 - b. The result of the initial injection was less than 75% reduction in pain; **or**
 - 2. For therapeutic injections, when **all** the following are met:
 - a. No more than four (4) injections per region performed in a 12-month period;
 - b. A minimum of 50% pain relief from the initial injection;
 - c. Pain relief lasted for a minimum of two (2) months; **and**
 - d. Active engagement in non-surgical conservative management with chiropractic care or supervised PT, unless intolerance due to pain is documented.
- XXII. Repeat sacroiliac injection(s) are considered **not medically necessary** for **ANY** of the following contraindications:
- A. Allergy to any component of the injectate;
 - B. Uncontrolled bleeding or clotting disorder;
 - C. Active infection; **or**
 - D. Pregnancy.

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 10 of 29

RELATED POLICIES

Corporate Medical Policy

7.01.124 Intraosseous Basivertebral Nerve Ablation for Safety Net Members

7.01.126 Spine Procedures for Safety Net Members

POLICY GUIDELINE(S)

- I. If an individual demonstrates improvement during the initial 6 weeks of PT, an additional 6 weeks of PT should be attempted prior to interventional pain management.
- II. Relative contraindications to ESI (caudal, interlaminar, transforminal) include **any** of the following:
 - A. Acute spinal cord compression;
 - B. Cauda equina syndrome or myelopathy;
 - C. Chronic immunosuppression;
 - D. Uncontrolled medical comorbidity(ies);
 - E. Clinical improvement to conservative management; **or**
 - F. For interlaminar ESI only: severe spinal stenosis.

DESCRIPTION

Definitions to support interventional pain management criteria:

- Activities of daily living (ADLs) refer to routine self-care activities required for independent daily functioning, including bathing, dressing, eating, toileting, and transferring between surfaces such as a bed and chair.
- Cauda equina syndrome is a neurologic emergency caused by compression of the lumbosacral nerve roots and may present with bowel or bladder dysfunction, saddle sensory changes, and motor or sensory deficits involving the lower extremities.
- Caudal epidural steroid injection (CESI) is a procedure in which contrast material (when not contraindicated), corticosteroid, and optionally a local anesthetic are introduced into the epidural space through the sacral hiatus under fluoroscopic guidance.
- Compression test is a sacroiliac joint provocation maneuver performed with the individual lying on their side, in which the examiner applies downward (vertical) pressure over the uppermost iliac crest/hip to compress the pelvis and stress the sacroiliac joints, assessing for reproduction of sacroiliac joint pain.
- Conservative management refers to non-surgical treatment strategies used to manage spinal pain and related conditions and may include physical therapy, medication therapy, chiropractic

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 11 of 29

care, and other non-operative interventions.

- Distraction test is a sacroiliac joint provocation maneuver in which outward pressure is applied across the pelvis to place stress on the sacroiliac joints and assess for symptom reproduction.
- Electrodiagnostic testing refers to neurophysiologic studies used to evaluate the function of peripheral nerves, muscles, and related neuromuscular structures.
- Epidural fibrosis refers to scar tissue formation adjacent to a spinal nerve root, most commonly occurring following spinal surgery.
- Epidural steroid injection (ESI) involves administration of a corticosteroid into the epidural space surrounding a spinal nerve root as a diagnostic and/or therapeutic intervention for radicular pain. Epidural injections may be performed using interlaminar, transforaminal, or caudal approaches.
- Flexion, abduction, and external rotation (FABER) Test, also known as Patrick's Test, is a provocative examination maneuver used in the assessment of pathology involving the hip, lumbar spine, or sacroiliac joint.
- Facet joint injections/medial branch blocks refer to the injection of local anesthetic, with or without corticosteroid, into a facet joint or along the medial branch nerves supplying the joint for the evaluation and treatment of facet-mediated pain.
- Failed back surgery syndrome (FBSS) describes persistent or recurrent pain following spinal surgery despite completion of the surgical procedure.
- Fluoroscopy is a real-time X-ray imaging modality that allows visualization of internal structures and procedural instruments during diagnostic and therapeutic interventions.
- Foraminal stenosis refers to narrowing of the neural foramen that may lead to irritation or compression of an exiting spinal nerve root.
- Gaenslen's test is a sacroiliac joint provocation maneuver that places stress across the pelvis and sacroiliac joint to assist in identifying pain arising from that region.
- Glucocorticosteroid refers to a class of medications commonly used for their anti-inflammatory and immunosuppressive properties.
- Immunosuppression refers to reduced immune system function resulting from disease, medication, or therapeutic intervention.
- Interlaminar epidural steroid injection (ILES) is a procedure in which contrast material (when not contraindicated), corticosteroid, and optionally a local anesthetic are delivered into the epidural space through an interlaminar approach under imaging guidance.
- Log roll test is a physical examination maneuver used primarily to evaluate for pathology arising from the hip joint.
- Medial branch transection, also known as endoscopic rhizotomy, is a surgical or endoscopic division of the medial branch nerves supplying the facet joints for the treatment of facet-

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 12 of 29

mediated pain.

- Myasthenia Gravis is an autoimmune neuromuscular disorder characterized by fluctuating skeletal muscle weakness resulting from impaired transmission at the neuromuscular junction.
- Myopathy refers to a disorder of muscle tissue characterized primarily by muscle weakness and, in some cases, cramping, stiffness, or pain.
- Nerve root disease, also referred to as radiculopathy, involves irritation or compression of a spinal nerve root that may result in pain, sensory disturbance, and/or motor dysfunction within the affected distribution.
- Neurotomy refers to the intentional interruption or division of a nerve for therapeutic purposes.
- Non-radicular pain refers to pain that is not caused by irritation or compression of a spinal nerve root and generally occurs without objective neurologic findings suggestive of radiculopathy.
- Paravertebral facet joints, also known as zygapophyseal joints or Z-joints, are articulations between adjacent vertebrae that may serve as a source of chronic spinal pain.
- Provocative test refers to a diagnostic maneuver designed to reproduce or exacerbate symptoms associated with a suspected condition.
- Pseudoarthrosis refers to failure of bony fusion following an attempted spinal fusion procedure.
- Radicular means relating to, involving, or arising from a spinal nerve root.
- Radiculitis refers to inflammation or irritation of a spinal nerve root that may result in pain and sensory symptoms.
- Radiculopathy refers to signs and symptoms caused by compression or irritation of a spinal nerve root, including pain, numbness, tingling, and/or weakness.
- Radiofrequency joint denervation/ablation refers to a minimally invasive procedure that uses thermal energy delivered through a radiofrequency probe to disrupt sensory nerve supply to a painful facet joint with the goal of reducing pain.
- Sacral thrust test is a sacroiliac joint provocation maneuver in which pressure is applied over the sacrum to reproduce symptoms arising from the sacroiliac joint.
- Sacroiliac (SI) joint injections involve administration of local anesthetic, with or without corticosteroid, into the sacroiliac joint for diagnostic evaluation and/or treatment of sacroiliac joint-mediated pain.
- Selective nerve root block (SNRB) is a diagnostic procedure in which anesthetic is injected around a specific spinal nerve root under imaging guidance to assist in identifying the symptomatic nerve root and/or for surgical planning.
- Spinal cord compression occurs when pressure on the spinal cord impairs normal neurologic function.
- Spinal instrumentation refers to surgically implanted devices, such as rods, screws, hooks, or

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 13 of 29

wires, used to stabilize and support the spine.

- Spinal stenosis is a condition characterized by narrowing of the spinal canal and/or neural foramina that may result in compression of neural structures.
- Spondylitis refers to inflammation involving the vertebrae or spinal joints.
- Spondylolisthesis refers to forward displacement of one vertebral body relative to the vertebra below it.
- Thigh thrust test is a sacroiliac joint provocation maneuver in which force is transmitted through the femur to stress the sacroiliac joint and reproduce symptoms.
- Transforaminal epidural steroid injection (TFESI) is a procedure in which contrast material (when not contraindicated), corticosteroid, and optionally a local anesthetic are introduced into the epidural space through the neural foramen under imaging guidance.

SUPPORTIVE LITERATURE

Epidural spinal injection (ESI) is one of several therapies available for people who fail conservative treatment, and is a common modality used for radicular pain and lumbar referred pain with several potentially painful conditions (e.g., neurogenic claudication) associated with degenerative or isthmic spinal stenosis.

Buenaventura et al (2009) conducted a systematic review to evaluate the effectiveness of lumbar TFESIs in managing chronic radicular pain. Of the four randomized, controlled trials evaluating TFESIs, all showed positive results for short-term relief. Two studies were positive for long-term relief; the results for long-term relief were not available for the third study, and the fourth study had negative long-term relief results.

Novak et al (2008) conducted a systematic review to evaluate the evidence in support of guidelines on frequency and timing of epidural steroid injections, to help determine what sort of response should occur to repeat an injection. The review included 11 randomized, controlled trials, one prospective controlled trial, and two prospective cohort studies. The authors concluded that there is limited evidence to suggest guidelines for frequency and timing of epidural steroid injections or to help define an appropriate partial response that would trigger a repeat injection. Research suggests that repeat injections may improve outcomes, but conclusions cannot be made due to methodological limitations of the available evidence. The authors further concluded that there does not appear to be any evidence to support the common practice of a series of injections.

Parr et al (2012) conducted a systematic review evaluating the effect of caudal epidural injections with or without steroids in managing various types of chronic low back and lower extremity pain, produced good evidence for short- and long-term relief of chronic pain secondary to disc herniation or radiculitis with local anesthetic and steroids, and fair relief with local anesthetic only. Further, this systematic review also provided only fair evidence for caudal epidural injections in managing chronic axial or discogenic pain, spinal stenosis, and post-surgery syndrome.

Lumbar Radiculopathy

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 14 of 29

In a Cochrane review, Oliveira et al (2020) published a systematic review and meta-analysis of 25 placebo-controlled randomized trials (n=2,470) evaluating the efficacy and safety of epidural corticosteroid injections for lumbosacral radicular pain. Moderate-quality evidence indicated that epidural corticosteroid injections were slightly more effective than placebo in reducing short-term leg pain and short-term disability (95% CI). However, the treatment effects were small and may not be considered clinically important (i.e., mean difference lower than 10%). Epidural corticosteroid injections were not more effective than placebo for reducing leg pain at intermediate or long-term follow-up. Adverse events were mostly minor (e.g., headache, accidental dural puncture, worsening pain), with no significant difference between groups. The authors concluded that the available evidence provides only limited support for the use of epidural corticosteroid injections in lumbosacral radicular pain, as benefits are small and largely confined to the short term.

Verheijen et al (2021) conducted a meta-analysis of 17 RCTs comparing ESI to epidural or nonepidural placebo in patients with sciatica. Studies were eligible for inclusion in the meta-analysis if they provided data on sciatica patients (any level of pain, any duration of symptoms, and any prior therapy). For back pain, ESI was not significantly more effective than epidural placebo at 6 weeks (p=.14), 3 months (p=.95), or 6 months (p=.53). GRADE quality of evidence was moderate at 6 weeks, very low at 3 months, and low at 6 months. When compared to nonepidural placebo, ESI resulted in greater relief of back pain at 3 months (p=.02) but not at 6 weeks or 6 months (quality of evidence: moderate). Based on low-quality evidence, leg pain was significantly improved with ESI compared to epidural placebo at 6 weeks (p<.01) and 3 months (p=.04), but not at 6 months (p=.31). In a sensitivity analysis adjusting for heterogeneity, leg pain was significantly improved with ESI compared to epidural placebo at all time points. Compared to nonepidural placebo, ESI did not significantly improve leg pain at any time point (quality of evidence: low to moderate). Functional status was significantly improved with ESI versus epidural placebo at 6 weeks (p<.01), but between-group differences were not significant at 3 months or 6 months (quality of evidence: moderate at 6 weeks, low at 3 months, and very low at 6 months). Compared to nonepidural placebo, ESI did not significantly improve functional status at any time point (quality of evidence: moderate). The patient population included in this review was not well-defined; therefore, it is unclear whether certain subpopulations may obtain greater benefit from ESI. Other limitations of the review include the relatively small number of studies available (particularly for the back pain outcome analyses and all comparisons between ESI and nonepidural placebo), the unclear clinical importance of the outcomes, and the variation in treatment success definitions across studies.

Cervical Radiculopathy

Cohen et al (2014) reported the results of an RCT that compared ESI, conservative treatment, and a combination of both for patients with cervical radiculopathy. A total of 169 patients were randomized to conservative care (physical therapy plus medications), ESIs, or a combination of both treatments. The primary outcomes were neck and arm pain measured at 1- and 3- months posttreatment. There were no differences noted between ESI and conservative care on any of the outcome measures. The group receiving combination therapy had a greater reduction in arm pain at 1 month compared with the two individual treatments and had a greater success rate at 3 months (56.9% vs. 26.8%, p=.006).

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 15 of 29

Borton et al (2022) performed a systematic review of cervical transforaminal ESIs for cervical radiculopathy. The review included six studies (3 RCTs and 3 observational studies; n=443). None of the included studies directly compared cervical transforaminal ESIs with other treatment options or placebo. Short-term (4 to 8 weeks) decreases in pain scores following injection varied greatly both within and between the six studies, and mean reduction in pain scores ranged from 18% to 70%. Four studies reported on longer-term pain relief (> 8 weeks), and mean reduction in pain scores ranged from 33% to 73%; however, there was a significant number of patients lost to follow-up in these studies.

Spinal Stenosis

Schneider et al (2019) published the results of a 3-arm RCT comparing the clinical effectiveness of medical care (n=88), group exercise (n=84), and manual therapy/individualized exercise (n=87) in patients with lumbar spinal stenosis. Treatment in the medical care group consisted of medications and/or ESI provided by a physiatrist. Study limitations include failure to disclose the proportion of patients in the medical care group that received ESI during the course of the study, excluding patients <60 years of age, and no direct reporting of pain outcomes. The primary outcomes were symptoms and physical function as measured by the patient-reported Swiss Spinal Stenosis (SSS) score. The SSS score ranges from 12 to 55 points, with higher scores indicating higher levels of self-reported disability. Analyses at 2 months indicated that manual therapy/individualized exercise demonstrated greater reduction in SSS score compared to medical care or group exercise. The magnitude of the difference in the reduction of SSS score between groups did not reach the level of a minimal clinically important difference of 3.02 points.

Failed Back Surgery Syndrome

The evidence is insufficient to determine that ESI results in an improvement in the net health outcome for individuals with failed back surgery syndrome (FBSS), also known as persistent spinal pain syndrome (PSPS) or post-laminectomy syndrome.

Celenlioglu et al (2022) investigated the efficacy of caudal epidural steroid injection (CESI) versus transforaminal epidural steroid injection (TFESI) in patients with post lumbar surgery syndrome (PLSS). In a prospective, randomized, assessor-blind study, a total of 56 patients (n = 26 CESI group; n = 30 TFESI group) were randomized and assessed at baseline, 1-hour, 3-weeks, and 3-months after the procedure. Treatment success was defined as a $\geq 50\%$ decrease in the Numeric Rating Scale (NRS-11) scores compared to baseline. NRS-11 and modified Oswestry Disability Index (mODI) scores showed a significant decline in both groups at all follow-ups ($p < 0.001$). At 3 weeks, the improvement in the mODI scores was significantly higher in the TFESI group ($p = 0.020$). In all follow-ups, the NRS-11 scores were similar between the groups. At 3 weeks, the rates of patients with a $\geq 50\%$ decrease in NRS-11 scores were 53.8% and 60% in the CESI group and TFESI group, respectively, while these rates were 30% and 26.7%, respectively, at 3 months. Although both CESI and TFESI were effective and safe methods in the treatment of PLSS caused by EF following lumbar discectomy, the study was limited by the lack of a placebo-controlled group and a short follow-up period.

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 16 of 29

Herpes Zoster Associated Pain (Active and Postherpetic Neuralgia)

A single case report described complete resolution of thoracic postherpetic neuralgia symptoms at 2- and 12-week follow-up after a transforaminal ESI (Mehta 2015); however, case-level evidence is insufficient to draw conclusions about efficacy.

Fujiwara et al (2018) conducted a randomized prospective trial comparing transforaminal (TF) and interlaminar (IL) epidural steroid injection approaches in patients (n=40) with acute-phase shingles. Patients were evaluated at baseline, 1 month, and 3 months using VAS and SF-36 scores. VAS scores at 1- and 3-month follow-up were significantly lower than baseline in both groups, with no significant difference between approaches. SF-36 scores and PHN incidence (defined as VAS >40 at 3 months) were also not significantly different between groups. The study was limited by a small sample size that did not meet power analysis requirements and a short follow-up period. The authors concluded that both IL and TF approaches improved pain scores, but neither demonstrated superiority.

Ghanavatian et al (2019) conducted a retrospective review of 42 patients with PHN managed by ESI at Mayo Clinic campuses from 1997 through 2018. A total of 97% of patients were treated with interlaminar ESI. Patients who reported poor ESI efficacy at 2 weeks had a 94% chance of continued pain at 12 weeks. Conversely, of the 24 patients who reported moderate-to-good pain relief at 2 weeks, 79% had persistent relief at 12 weeks. PHN duration <11 months was predictive of moderate-to-good pain relief at 12 weeks (positive predictive value 55.2%). However, no patient characteristics, concurrent medications, or type of intervention were significantly associated with ESI efficacy. The study was limited by its retrospective design and small sample size.

Choi et al (2020) conducted a prospective, double-blind, randomized controlled trial comparing a single 5 mg epidural dexamethasone dose (group A) with intermittent repeated doses totaling 15 mg (group B) in patients (n=42) with zoster-associated pain (ZAP) beyond the acute phase (30–180 days after rash onset). The primary outcome was change in NRS pain score and the secondary outcome was complete remission of PHN. The percentage of patients with ≥50% pain reduction was not significantly different between groups (p = 0.110). However, complete remission of PHN was significantly higher in group B (80.95%) than group A (28.57%, p = 0.001). The study was limited by the lack of a placebo control group, small sample size, and exclusion of patients with well-established PHN (>180 days).

Chuang et al (2025) performed a systematic review and meta-analysis of 13 studies (9 RCTs [n=815] and 4 observational studies [n=253]) evaluating various nerve blocks for acute herpes zoster, including paravertebral blocks (PVB), erector spinae plane (ESP) blocks, epidural blocks, and intercostal nerve blocks. The meta-analysis of 6 RCTs showed that nerve blocks significantly reduced VAS pain scores at 4 weeks but not at 12 weeks. PVB and ESP blocks significantly decreased PHN incidence at 3 and 6 months. Notably, the four observational studies comparing epidural or intercostal nerve blocks with other techniques provided only weak evidence for their use, highlighting the need for more high-quality RCTs specifically evaluating epidural approaches for acute herpes zoster.

Ultrasound-Guided ESI

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 17 of 29

There is limited peer-reviewed literature regarding the overall health benefit of ultrasound guidance during epidural steroid injections compared to fluoroscopy or CT guidance.

Jang et al (2020) conducted a retrospective comparative review of 122 patients to compare ultrasound (US)-guided selective nerve root block (SNRB; n=44), fluoroscopy (FL)-guided interlaminar cervical epidural steroid injection (IL-CESI; n=41), and FL-guided transforaminal CESI (TF-CESI; n=37) for radicular pain in the lower cervical spine. Neck Disability Index and pain scores improved at 1, 3, and 6 months in all groups, with no significant differences between groups. No intravascular contrast spread was observed in the US-guided group, compared with 2 patients in the FL-guided IL group and 7 in the FL-guided TF group. Despite the advantages of no radiation exposure and real-time visualization of soft tissue structures, the authors acknowledged that ultrasound technique is operator-dependent and cannot independently confirm the spinal level reached by the injectate.

Ahmed et al (2023) performed a meta-analysis of seven randomized controlled trials comparing ultrasonography (USG)-guided versus conventional fluoroscopy (FL)-guided ESIs for radiculopathy. There was no statistically significant difference in pain reduction between groups at the lumbosacral level at 1 month or 3 months. Functional improvement was also comparable between groups. USG guidance was associated with a significantly lower risk of inadvertent vascular puncture (OR 0.21; 95% CI 0.07–0.64) and shorter procedure time compared to FL guidance. There was no significant difference in the need for repeat ESIs between groups. Study limitations include heterogeneity due to inclusion of both cervical and lumbosacral levels, different epidural approaches, and different steroids used. The authors concluded that USG-guided ESIs are noninferior to FL-guided ESIs in terms of pain reduction and functional improvement.

Kimura et al (2023) conducted a systematic review and meta-analysis of 8 RCTs (n=962) to compare US-guided versus FL- or CT-guided spinal nerve injections. There was little to no difference in pain reduction or functional disability between groups. US guidance probably reduced major adverse events (0.7% vs 6.5%) and minor adverse events (2.1% vs 4.2%), and significantly reduced procedure time (MD -4.19 min; 95% CI -5.09 to -3.30). The authors concluded that US-guided injections remained effective while reducing adverse events compared to conventional guidance.

Injectates – Biologics (e.g., Platelet Rich Plasma, Stem Cells, Amniotic Fluid)

Sanapati et al (2018) conducted a systematic review and single-arm meta-analysis of the effectiveness of platelet-rich plasma (PRP) and mesenchymal stem cell (MSC) injections in managing low back and lower extremity pain. Twenty-one studies met inclusion criteria (12 lumbar disc injections, 5 epidural, 3 lumbar facet joint, and 3 sacroiliac joint studies). Disc injections of PRP and MSCs showed Level III evidence, while epidural, facet joint, and sacroiliac joint injections demonstrated Level IV evidence. The authors concluded that MSCs and PRP may be effective in managing discogenic low back pain, radicular pain, facet joint pain, and sacroiliac joint pain, but the evidence lacked high-quality randomized controlled trials.

Wang and Zhang (2025) conducted a systematic review and meta-analysis of 7 studies (4 RCTs and 3 prospective studies; n=416) comparing epidural PRP versus corticosteroid injection for lumbar

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 18 of 29

radicular pain. Corticosteroids significantly reduced Oswestry Disability Index (ODI) scores at 4 weeks ($p = 0.0008$), with no significant differences in VAS or ODI scores between groups at other time points. Complication rates were similar, though incomplete reporting may underestimate risks. The authors concluded that PRP did not demonstrate superior improvements over corticosteroid injections for lumbar radicular pain, while corticosteroids showed significant short-term functional improvement. The review was limited by low study quality and heterogeneity in PRP preparation methods.

Generally, the outcomes from clinical studies reflect that a diagnostic facet joint injection may assist in determining whether specific interventions targeting the facet joint are indicated.

Manchikanti et al (2015) stated that despite interventional procedures being common as treatment strategies for facet joint pathology, there is a paucity of literature investigating these therapeutic approaches. A systematic review and best evidence synthesis of the effectiveness of therapeutic facet joint interventions in managing chronic spinal pain was conducted to evaluate and update the clinical utility of therapeutic lumbar, cervical, and thoracic facet joint interventions in managing chronic spinal pain. A total of 21 randomized controlled trials (RCTs) and 5 observational studies were assessed. The limitations of this systematic review include an overall paucity of high-quality studies and the lack of investigations related to thoracic facet joint injections. Based on the present assessment for the management of spinal facet joint pain, the evidence for long-term improvement is Level II for therapeutic facet joint nerve blocks in the cervical, thoracic, and lumbar spine.

Wardhana et al (2022) acknowledge that a few studies have explored the effectiveness of facet interventions for chronic lumbar pain, but there has been no clear consensus of which procedures are more superior. In a meta-analysis, this study aimed to compare the effectiveness of corticosteroid injection (CI) and radiofrequency (RF) ablation for the treatment of lumbar facet joint (LFJ) pain. In total, 7 studies ($n=552$ patients) were included in the analysis. The corticosteroid agents were methylprednisolone in 4 trials, betamethasone in 2 trials, and dexamethasone in 1 trial. Pulsed RF was performed in 4 trials, whereas continuous RF was performed in 3 trials. Treatment with CI was associated with higher pain intensity score than RF ablation (3 trials; $p < 0.00001$), with substantial heterogeneity. Pain intensity scores at 6 months were significantly higher in patients treated with CI than RF ablation (7 trials, $p = 0.0002$), with substantial heterogeneity. The estimated effect of CI on pain intensity score at 12 months when CI was compared to RF ablation showed a statistically insignificant increase ($p = 0.08$), with substantial heterogeneity. Overall, the authors concluded that the pooled analysis from limited trials showed a benefit of RF to the improvement of pain intensity and functional disability when comparing RF with CI for the treatment of LFJ pain.

Pasuhirunnikorn et al (2023) evaluated the effect of prolonged concordant response and functional clinical improvement between lidocaine and bupivacaine for cervical medial branch block (CMBB) in chronic cervical facet syndrome. Sixty-two patients diagnosed with chronic cervical facet syndrome were randomized into either lidocaine or bupivacaine groups. The patients, pain assessor, and pain specialist were blinded. The therapeutic CMBB was performed under ultrasound guidance. Either 2% lidocaine or 0.5% bupivacaine with a volume of 0.5-1 milliliter (mL) per level was injected according to the patient's pain symptoms. The primary outcome was the duration of pain reduction by at least 50%. The Numerical Rating Scale (NRS) of 0-10 and the Neck Disability Index questionnaire were

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 19 of 29

recorded. There was no significant difference in the duration of 50% and 75% pain reduction and Neck Disability Index between the lidocaine and bupivacaine groups. Lidocaine provided significant pain reduction up to 16 weeks ($P < 0.05$) and significant improvement in neck functional outcomes up to 8 weeks ($P < 0.01$) compared to the baseline. Bupivacaine yielded significant pain alleviation for up to 8 weeks for pain upon neck mobilization ($P < 0.05$) and demonstrated notable improvement in neck function up to 4 weeks ($P < 0.01$) compared to the baseline. CMBB using lidocaine or bupivacaine provided clinical benefits in prolonged analgesic effect and improving neck functions for chronic cervical facet syndrome. Lidocaine illustrated better performance and could be considered a local anesthetic of choice regarding the prolonged concordance response.

Manchikanti et al (2024) evaluated the effectiveness of facet joint nerve blocks as a therapeutic modality in managing chronic axial spinal pain of facet joint origin by conducting a systematic review and meta-analysis of randomized controlled trials (RCTs) and observational studies. The primary outcome measure was the proportion of patients with significant relief and functional improvement of greater than 50% of at least 3 months. Duration of relief was categorized as short-term (less than 6 months) and long-term (greater than 6 months). Despite the availability of multiple studies, the paucity of literature is considered as the major drawback. Based on the present systematic review and meta-analysis with 9 RCTs and 12 non-randomized studies, the evidence is Level II with moderate to strong recommendation for therapeutic facet joint nerve blocks in managing spinal facet joint pain.

PROFESSIONAL GUIDELINE(S)

Facet Joint Interventions for Management of Chronic Spinal Pain

In 2020, the American Society of Interventional Pain Physicians (ASIPP) published guidelines on facet joint interventions for management of chronic spinal pain (Manchikanti 2020).

- Facet joint nerve blocks for diagnosis are recommended with moderate to strong strength for the lumbar spine (evidence level I–II), moderate strength for the cervical spine (evidence level II), and moderate strength for the thoracic spine (evidence level II), using a criterion standard of $\geq 80\%$ pain relief with dual comparative blocks.
- Radiofrequency ablation for treatment is recommended with moderate strength for the lumbar and cervical spine (evidence level II) and weak to moderate strength for the thoracic spine (evidence level III).
- Facet joint nerve blocks are recommended for treatment of pain in the lumbar spine (moderate strength recommendation; evidence level II), cervical spine (moderate strength recommendation; evidence level II), and thoracic spine (weak to moderate strength recommendation; evidence level III).
- Intra-articular injections received a weak recommendation with lower levels of evidence (level III–V across spinal regions).

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 20 of 29

Sacroiliac Joint – Ablation and Injection

In 2020, North American Spine Society (NASS) acknowledge the limited available data and that the optimal procedural technique has not been established. However, based on this limited data, NASS indicates it is reasonable to offer coverage for thermal radiofrequency neurotomy at the L5 dorsal ramus and S1-S3 sacral lateral branches for SIJ pain. NASS does not include recommendation details for other ablative techniques (e.g., pulsed RF, laser, cooled RF, cryoablation).

The American Society of Pain and Neuroscience (ASPN) Best Practice Guideline for the Treatment of Sacroiliac Disorders (Sayed 2024) recommends RFA of the lateral branches of the S1-S3 dorsal rami along with the L5 dorsal rami (and possibly L4) after an appropriate trial of conservative care and appropriate response to diagnostic blockade. Dual diagnostic blockade of the L5 dorsal ramus and S1-S3 sacral lateral branches with $\geq 50\%$ improvement in pain and function is the preferred strategy prior to neuroablative procedures. The ASPN notes that rarer modalities such as intra-articular chemical neurolysis and cryoablation have low-quality evidence supporting mild efficacy with limitations due to adverse effect profile.

In 2025, the American Academy of Pain Medicine (AAPM) and American Society of Regional Anesthesia & Pain Medicine (ASRA-PM) issued multispecialty consensus practice guidelines on SIJ complex pain (McCormick 2025), developed by an international working group, and endorsed by 21 organizations. The consensus found strong evidence for sacral lateral branch RFA to provide relief for at least 6 months in individuals with extra-articular pathology. The guidelines recommend targeting S1-S3 lateral branches in all patients (Grade A, high certainty), with consideration of the L5 dorsal ramus and S4 lateral branch based on individual anatomy (Grade B, moderate certainty). Stronger evidence supports larger lesions or more aggressive lesioning strategies over less stringent techniques. The evidence for cryoablation was found to be very limited.

For radicular pain, the North American Spine Society (NASS) (2020) finds that there is sufficient literature to suggest that a trial of ESIs for radicular pain caused by conditions other than disc herniation is appropriate prior to considering surgical intervention. NASS cites multiple randomized-controlled trials (RCTs) that demonstrate lumbar epidural steroid injections (LESIs) are effective in the treatment of lumbar radiculitis caused by disc herniation. Similarly, citing that several conditions may cause cervical radicular pain, with literature regarding interlaminar (IL) ESIs demonstrating durable improvements in pain and disability for 12 and 24 months for a variety of cervical pathologic conditions. The literature on cervical transforaminal (TF) ESIs is limited to observational studies including reduction in surgical intervention has been demonstrated, and the biochemical pathology involved is likely similar to lumbar radicular etiologies.

For lumbar referred pain, NASS (2020) finds that the literature suggests LESIs are effective in reducing pain in this patient population. It is noted that this treatment seems to be less effective in this group than in patients with herniated discs. In addition, data show that LESI is equivalent to epidural local anesthetic likely due to the suppression of neurogenic inflammation by the local anesthetic. Based on these data, it is felt that a trial of LESIs is reasonable prior to the consideration of surgical intervention.

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 21 of 29

NASS' (2020) evidence-based clinical guidelines for diagnosis and treatment of low back pain reported that there is insufficient evidence to make a recommendation for or against the use of caudal or interlaminar epidural steroid injections in patient with low back pain (Grade I).

The American Society of Interventional Pain Physicians (ASIPP) published comprehensive evidenced-based guidelines for facet joint interventions in the management of chronic spinal pain (Manchikanti 2020). Patients testing positive for facet joint pain may undergo either therapeutic facet joint nerve blocks or radiofrequency neurotomy based on patients' preferences, values, and physician expertise. Once facet joint pain is excluded, the patient may be treated with epidural injections.

The American Society of Interventional Pain Physicians (ASIPP) published an updated guideline on the use of epidural injections in the management of chronic spinal pain (Manchikanti 2021). The following recommendations were made

- For patients with disc herniation:
 - o The evidence is Level I for caudal epidural injections, lumbar interlaminar epidural injections, lumbar transforaminal epidural injections, and cervical interlaminar epidural injections with strong recommendation for long-term effectiveness.
 - o For thoracic disc herniation, based on one relevant, high-quality RCT of thoracic epidural with fluoroscopic guidance, with or without steroids, the evidence is Level II with moderate to strong recommendation for long-term effectiveness.
- For patients with spinal stenosis:
 - o Based on one high-quality RCT in each category the evidence is Level III to II for fluoroscopically guided caudal epidural injections with moderate to strong recommendation and Level II for fluoroscopically guided lumbar and cervical interlaminar epidural injections with moderate to strong recommendation for long-term effectiveness.
 - o The evidence for lumbar transforaminal epidural injections is Level IV to III with moderate recommendation with fluoroscopically guided lumbar transforaminal epidural injections for long-term improvement.
- For patients with axial discogenic pain, the evidence for axial discogenic pain without facet joint pain or sacroiliac joint pain in the lumbar and cervical spine with fluoroscopically guided caudal, lumbar and cervical interlaminar epidural injections, based on one relevant high quality RCT in each category is Level II with moderate to strong recommendation for long-term improvement, with or without steroids.
- For acute proven disc herniation with radiculitis with disabling pain or to avoid surgical intervention, herpes zoster, post herpetic neuralgia, CRPS I and II, epidural injections may be performed at physician discretion without additional pain duration or conservative management requirements.

A 2022 American Society of Pain and Neuroscience (ASPN) guideline provides recommendations for the use of epidural steroid injections in the treatment of low back pain (Sayed 2022). Grade A

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 22 of 29

consensus recommendations include:

- Interlaminar epidural injections for treatment of low back and radicular pain originating from disc disease, spinal stenosis and for chronic back/leg pain after surgical intervention.
- Transforaminal epidural injections for treatment of low back and radicular pain originating from disc disease, spinal stenosis and for chronic back/leg pain after surgical intervention.
- Caudal epidural injections for treatment of low back and radicular pain originating from disc disease, spinal stenosis and for chronic back/leg pain after surgical intervention when interlaminar or transforaminal approaches are not feasible
- Use of either steroid or local anesthetic or the two classes of medication in combination for use in epidural injections for treatment of low back and radicular pain originating from disc disease, spinal stenosis and for chronic back/leg pain after surgical intervention.

In 2022, ASPN provided updated consensus guidance regarding best practices for minimally invasive lumbar spinal stenosis treatment (MIST) (Deer 2022). The guidelines note that most trials, on lumbar ESI, have demonstrated efficacy but there is considerable variability regarding epidural technique, medication, dosage, and duration of improvement. As a result, treatment efficacy for the modality has been difficult to determine, as foundational studies in support of the procedure come from different eras representing the evolution of evidence-based medicine and evidence-based study standards.

- Epidural steroid injections are recommended in the algorithm for the treatment of symptomatic lumbar spinal stenosis. Grade B; Level of certainty high; Level of evidence I-A)
- Epidural steroid injections may be repeated when a patient has significant temporary improvement in symptoms. Be aware that the number and frequency of injections may be limited by insurance and payer rules and regulations. Grade B; Level of certainty moderate; Level of evidence I-B).

In 2025, the American Academy of Neurology (AAN) Guidelines Subcommittee conducted a systematic review of 90 RCTs on the efficacy of epidural steroids for cervical and lumbar radicular pain and spinal stenosis published between January 2005 and January 2021 (Armon 2025). The review affirms limited efficacy of ESIs in reducing pain and disability in cervical and lumbar radiculopathies and possibly in lumbar spinal stenosis, largely in the short term. The panel made the following conclusions:

- For patients with cervical or lumbar radiculopathy, ESIs probably reduce short-term disability (moderate confidence).
- For patients with lumbar spinal stenosis, ESIs possibly reduce short-term disability (low confidence, confidence downgraded for heterogeneity). There were no studies evaluating ESIs in cervical spinal stenosis.
- For patients with cervical or lumbar radiculopathy, ESIs possibly decrease long-term disability (low confidence).

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 23 of 29

- For patients with lumbar spinal stenosis, ESIs possibly reduce long-term disability (low confidence). There were no studies evaluating cervical stenosis.
- For patients with cervical or lumbar radiculopathy, ESIs probably provide short-term pain reduction (moderate confidence).
- For patients with lumbar spinal stenosis, ESIs probably do not provide short-term pain reduction (moderate confidence). No studies were available for cervical stenosis.
- For patients with cervical or lumbar spinal radiculopathy, there is insufficient evidence to determine whether ESIs provide long-term pain reduction (very low confidence).
- For patients with lumbar spinal stenosis, there is insufficient evidence to determine whether ESIs reduce long-term pain (very low confidence). There were no studies evaluating cervical stenosis.
- Epidural steroid injections are possibly equally effective in patients with lumbar and cervical disease (low confidence, anchored by imprecision), considering that there is only 1 RCT meeting inclusion criteria for cervical radiculopathy.
- There is no significant difference between interlaminar, transforaminal, and caudal ESIs in the outcomes of short-term disability or pain or long-term disability or pain.

Ultrasound Guidance

In 2020, the North American Spine Society (NASS) published coverage policy recommendations for epidural steroid injections & selective spinal nerve blocks which indicates there is insufficient safety and efficacy data to support ultrasound guidance for any approach delivering ESI.

Injectates – Biologics (e.g., Platelet Rich Plasma, Stem Cells, Amniotic Fluid)

The American Society of Pain and Neuroscience (ASPN) identified the educational need for an evidence-based guideline on regenerative medicine therapy for chronic pain and convened a multispecialty working group to evaluate the evidence (D'Souza 2024). The expert panel made the following relevant statements:

- Consensus Point 29. While epidural injections with autologous-conditioned serum (ACS) may improve radicular pain symptoms, some evidence suggests that it is not superior to corticosteroid injection (Level I, Grade C).
- Consensus Point 30. Epidural injections with PRP or other PRP-related products may alleviate radicular pain symptoms in radiculopathy, although studies had a high risk for bias (Level I, Grade C).
- Consensus Point 34. PRP injection at the site of pain for post-herpetic neuralgia as an adjunct to oral neuropathic analgesics may be associated with improved pain intensity compared to medications alone (Level II-2, Grade C).

In 2025, the American Society of Interventional Pain Physicians (ASIPP) published comprehensive evidence-based guidelines for regenerative therapies in the management of chronic low back pain (Manchikanti 2025). The panel made the following relevant statements:

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 24 of 29

- Epidural injections with PRP are supported by Level III (fair) evidence, with a moderate consensus-based clinical recommendation.
- Intradiscal injections with PRP are supported by Level III (fair) evidence, with a moderate consensus-based clinical recommendation.
- Intradiscal injections with bone marrow aspirate concentrate (BMAC) are supported by Level III (fair) evidence, with a moderate consensus-based clinical recommendation.
- Facet joint injections with PRP and MSCs are supported by Level IV (limited) evidence, with a moderate consensus-based clinical recommendation.

Sacroiliac joint injections with PRP are supported by Level IV (limited) evidence, with a low consensus-based clinical recommendation.

REGULATORY STATUS

The U.S. Food and Drug Administration (FDA) regulates devices and instruments used during interventional pain procedures as medical devices. All devices and instruments including related components require FDA approval before marketing and use in the United States to ensure they are safe and effective for human use. Refer to the FDA Medical Device website. Available from: <https://www.fda.gov/medical-devices> [accessed 2026 Sept 12]

The FDA lists the most serious type of medical device recalls as well as early alert communications about corrective actions being taken by companies that the FDA believes are likely to be the most serious type of recalls. Available from: <https://www.fda.gov/medical-devices/medical-device-safety/medical-device-recalls-and-early-alerts> [accessed 2026 Sept 12]

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
Epidural Steroid Injection	
62320	Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 25 of 29

Code	Description
62321	Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (i.e., fluoroscopy or CT)
62322	Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
62323	Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (i.e., fluoroscopy or CT)
64479	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level
64483	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level
Facet Joint Injections / Medial Branch Blocks	
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
0213T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; single level
0216T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; single level
Paravertebral facet joint radiofrequency neurolysis / medial branch transection	
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 26 of 29

Code	Description
Sacroiliac Joint Injection	
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography)
G0260	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography

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HCPCS Codes

Code	Description
Not Applicable	

ICD10 Codes

Code	Description
Multiple Codes	

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Policy Number: 7.01.122

Page: 27 of 29

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SEARCH TERMS

Not Applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

[Facet Joint Interventions for Pain Management \(LCD L35936\)](#) [accessed 2026 Sep 10]

[Epidural Steroid Injections for Pain Management \(LCD L39036\)](#) [accessed 2026 Sep 10]

[Sacroiliac Joint Injections and Procedures \(LCD L39455\)](#) [accessed 2026 Sep 10]

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.

Medical Policy: Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

Policy Number: 7.01.122

Page: 29 of 29

- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION	
Committee Approval Dates	
09/17/26	
Date	Summary of Changes
01/01/27	• Original effective date
09/17/26	• New policy