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**Status:** Revised
**Doc ID:** MSK01-0624.3
**Effective Date:** 06/30/2024
**Last Review Date:** 04/15/2024

Approval and implementation dates for specific health plans may vary. Please consult the applicable health plan for more details.

Clinical Appropriateness Guidelines

# Musculoskeletal

# Appropriate Use Criteria: Interventional Pain Management

**Proprietary**

# Table of Contents

# Description and Application of the Guidelines

The Carelon Clinical Appropriateness Guidelines (hereinafter “the Carelon Clinical Appropriateness Guidelines” or the “Guidelines”) are designed to assist providers in making the most appropriate treatment decision for a specific clinical condition for an individual. The Guidelines establish objective and evidence-based criteria for medical necessity determinations, where possible, that can be used in support of the following:

- To establish criteria for when services are medically necessary
- To assist the practitioner as an educational tool
- To encourage standardization of medical practice patterns
- To curtail the performance of inappropriate and/or duplicate services
- To address patient safety concerns
- To enhance the quality of health care
- To promote the most efficient and cost-effective use of services

The Carelon guideline development process complies with applicable accreditation and legal standards, including the requirement that the Guidelines be developed with involvement from appropriate providers with current clinical expertise relevant to the Guidelines under review and be based on the most up-to-date clinical principles and best practices. Resources reviewed include widely used treatment guidelines, randomized controlled trials or prospective cohort studies, and large systematic reviews or meta-analyses. Carelon reviews all of its Guidelines at least annually.

Carelon makes its Guidelines publicly available on its website. Copies of the Guidelines are also available upon oral or written request. Additional details, such as summaries of evidence, a list of the sources of evidence, and an explanation of the rationale that supports the adoption of the Guidelines, are included in each guideline document.

Although the Guidelines are publicly available, Carelon considers the Guidelines to be important, proprietary information of Carelon, which cannot be sold, assigned, leased, licensed, reproduced or distributed without the written consent of Carelon.

Carelon applies objective and evidence-based criteria, and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services. The Carelon Guidelines are just guidelines for the provision of specialty health services. These criteria are designed to guide both providers and reviewers to the most appropriate services based on a patient’s unique circumstances. In all cases, clinical judgment consistent with the standards of good medical practice should be used when applying the Guidelines. Guideline determinations are made based on the information provided at the time of the request. It is expected that medical necessity decisions may change as new information is provided or based on unique aspects of the patient’s condition. The treating clinician has final authority and responsibility for treatment decisions regarding the care of the patient and for justifying and demonstrating the existence of medical necessity for the requested service. The Guidelines are not a substitute for the experience and judgment of a physician or other health care professionals. Any clinician seeking to apply or consult the Guidelines is expected to use independent medical judgment in the context of individual clinical circumstances to determine any patient’s care or treatment.

The Guidelines do not address coverage, benefit or other plan specific issues. Applicable federal and state coverage mandates take precedence over these clinical guidelines, and in the case of reviews for Medicare Advantage Plans, the Guidelines are only applied where there are not fully established CMS criteria. If requested by a health plan, Carelon will review requests based on health plan medical policy/guidelines in lieu of the Carelon Guidelines. Pharmaceuticals, radiotracers, or medical devices used in any of the diagnostic or therapeutic interventions listed in the Guidelines must be FDA approved or conditionally approved for the intended use. However, use of an FDA approved or conditionally approved product does not constitute medical necessity or guarantee reimbursement by the respective health plan.

The Guidelines may also be used by the health plan or by Carelon for purposes of provider education, or to review the medical necessity of services by any provider who has been notified of the need for medical necessity review, due to billing practices or claims that are not consistent with other providers in terms of frequency or some other manner.

# General Clinical Guideline

## Clinical Appropriateness Framework

Critical to any finding of clinical appropriateness under the guidelines for a specific diagnostic or therapeutic intervention are the following elements:

- Prior to any intervention, it is essential that the clinician confirm the diagnosis or establish its pretest likelihood based on a complete evaluation of the patient. This includes a history and physical examination and, where applicable, a review of relevant laboratory studies, diagnostic testing, and response to prior therapeutic intervention.
- The anticipated benefit of the recommended intervention is likely to outweigh any potential harms, including from delay or decreased access to services that may result (net benefit).
- Widely used treatment guidelines and/or current clinical literature and/or standards of medical practice should support that the recommended intervention offers the greatest net benefit among competing alternatives.
- There exists a reasonable likelihood that the intervention will change management and/or lead to an improved outcome for the patient.

Providers may be required to submit clinical documentation in support of a request for services. Such documentation must a) accurately reflect the clinical situation at the time of the requested service, and b) sufficiently document the ordering provider's clinical intent.

If these elements are not established with respect to a given request, the determination of appropriateness will most likely require a peer-to-peer conversation to understand the individual and unique facts that would justify a finding of clinical appropriateness. During the peer-to-peer conversation, factors such as patient acuity and setting of service may also be taken into account to the extent permitted by law.

## Simultaneous Ordering of Multiple Diagnostic or Therapeutic Interventions

Requests for multiple diagnostic or therapeutic interventions at the same time will often require a peer-to-peer conversation to understand the individual circumstances that support the medical necessity of performing all interventions simultaneously. This is based on the fact that appropriateness of additional intervention is often dependent on the outcome of the initial intervention.

Additionally, either of the following may apply:

- Current literature and/or standards of medical practice support that one of the requested diagnostic or therapeutic interventions is more appropriate in the clinical situation presented; or
- One of the diagnostic or therapeutic interventions requested is more likely to improve patient outcomes based on current literature and/or standards of medical practice.

## Repeat Diagnostic Intervention

In general, repeated testing of the same anatomic location for the same indication should be limited to evaluation following an intervention, or when there is a change in clinical status such that additional testing is required to determine next steps in management. At times, it may be necessary to repeat a test using different techniques or protocols to clarify a finding or result of the original study.

Repeated testing for the same indication using the same or similar technology may be subject to additional review or require peer-to-peer conversation in the following scenarios:

- Repeated diagnostic testing at the same facility due to technical issues
- Repeated diagnostic testing requested at a different facility due to provider preference or quality concerns

- Repeated diagnostic testing of the same anatomic area based on persistent symptoms with no clinical change, treatment, or intervention since the previous study
- Repeated diagnostic testing of the same anatomic area by different providers for the same member over a short period of time

## Repeat Therapeutic Intervention

In general, repeated therapeutic intervention in the same anatomic area is considered appropriate when the prior intervention proved effective or beneficial and the expected duration of relief has lapsed. A repeat intervention requested prior to the expected duration of relief is not appropriate unless it can be confirmed that the prior intervention was never administered. Requests for on-going services may depend on completion of previously authorized services in situations where a patient's response to authorized services is relevant to a determination of clinical appropriateness.

# Epidural Injection Procedures and Diagnostic Selective Nerve Root Blocks

## Description

Epidural steroid injection (ESI) involves the administration of corticosteroid via insertion of a needle into the epidural space surrounding the spinal neural elements. Despite the lack of consistent evidence to support its efficacy, the procedure is widely used in patients with chronic back, neck, and radicular pain. In 2014, the U.S. Food and Drug Administration issued a drug safety communication about epidural injection of corticosteroids, citing the risk for rare but serious adverse effects (loss of vision, stroke, paralysis, and death). The best evidence supporting its use comes from trials that looked specifically at patients with radiculopathy due to disc herniation, where short-term benefit has been demonstrated.

Injections may be performed as part of a diagnostic workup of radicular pain, or as a therapeutic modality when multiple noninvasive treatment strategies have failed. Injections may be performed via an interlaminar approach, transforaminal approach, or caudal approach (through the sacral hiatus).

Diagnostic selective nerve root block (SNRB) is a related procedure that utilizes a small amount of anesthetic, injected via transforaminal approach, to anesthetize a specific spinal nerve root without spreading into the epidural space. Diagnostic SNRBs are used to evaluate a patient's anatomical level and/or source of radicular pain that is not clear on imaging studies and are often used in presurgical planning and decision making.

## Clinical Indications

*The following general requirements apply to all indications except where they differ from the specific requirements. The specific requirements take precedence over any stated general requirement.*

### General Information

The terms in the section provide operational definitions when they are referenced as requirements in the guideline.

Documentation supporting medical necessity should be submitted at the time of the request and must include the following components:

**Conservative management**[1] should include a combination of strategies to reduce inflammation, alleviate pain, and correct underlying dysfunction, including physical therapy **AND** at least one complementary conservative treatment strategy.

- **Physical therapy requirement** includes **ANY** of the following:
    - Physical therapy rendered by a qualified provider of physical therapy services
    - Supervised home treatment program that includes **ALL** of the following:
        - Participation in a patient specific or tailored program
        - Initial active instruction by MD/DO/PT with redemonstration of patient ability to perform exercises
        - Compliance (documented or by clinician attestation on follow-up evaluation)
    - Exception to the physical therapy requirement in unusual circumstances (for instance, intractable pain so severe that physical therapy is not possible) when clearly documented in the medical record
- **Complementary conservative treatment requirement** includes **ANY** of the following:

- Anti-inflammatory medications and analgesics[2]
- Adjunctive medications such as nerve membrane stabilizers or muscle relaxants[2]
- Alternative therapies such as acupuncture, chiropractic manipulation, massage therapy, activity modification, and/or a trial period of rest (e.g., from the aggravating/contributing factors) where applicable

[1] Additional condition or procedure-specific requirements may apply and can be found in the respective sections of the guideline.

[2] In the absence of contraindications

**Clinical reevaluation**. In most cases, reevaluation should include a physical examination. Direct contact by other methods, such as telephone communication or electronic messaging, may substitute for in-person evaluation when circumstances preclude an office visit.

**Failure of conservative management** requires **ALL** of the following:

- Patient has completed a full course of conservative management (as defined above) for the current episode of care
- Worsening of or no significant improvement in signs and/or symptoms upon clinical reevaluation
- More invasive forms of therapy are being considered

Documentation of compliance with a plan of therapy that includes elements from these areas is required where conservative management is appropriate.

**Reporting of symptom severity**: Severity of pain and its associated impact on activities of daily living (ADLs) and instrumental ADLs (IADLs) are key factors in determining the need for intervention. For purposes of this guideline, significant pain and functional impairment refer to pain that is at least 3 out of 10 in intensity and is associated with inability to perform at least two (2) ADLs and/or IADLs.

**Imaging studies**: All imaging must be performed and read by an independent radiologist. If discrepancies should arise in the interpretation of the imaging, the radiology report will supersede. The results of all imaging studies should correlate with the clinical findings in support of the requested procedure.

### Procedural Best Practices to Prevent Neurologic Complications

All providers are expected to adhere to the procedural best practices for epidural steroid injections established by the U.S. Food and Drug Administration (FDA) Safe Use Initiative in 2015. The FDA Safe Use Initiative convened an expert multidisciplinary working group and 13 specialty stakeholder societies to review the existing evidence regarding neurologic complications associated with epidural corticosteroid injections. Seventeen procedural clinical considerations aimed at enhancing the safety of these injections, including the appropriate use of particulate steroids, were published. Providers are strongly encouraged to review the consensus opinions of the multidisciplinary working group (see Safeguards to Prevent Neurologic Complications after Epidural Steroid Injections: Consensus Opinions from a Multidisciplinary Working Group and National Organizations, available at: https://anesthesiology.pubs.asahq.org/article.aspx?articleid=2119175).

*Note: Preauthorization is required for notification purposes only (medical necessity review is not required) when CPT 62320 and 62322 are used for post-procedural pain with any of the following ICD-10-CM diagnoses: G89.11 Acute pain due to trauma, G89.12 Acute post-thoracotomy pain, or G89.18 Other acute post procedural pain.*

## Epidural Injections

### Procedural Requirements and Restrictions

- Injections must be performed under fluoroscopy or CT guidance, unless CT or fluoroscopy cannot be performed due to contraindications.
- A maximum of one spinal region may be treated per session (date of service). An anatomic spinal region for epidurals is defined as cervical/thoracic or lumbar/sacral.

- A maximum of four (4) therapeutic injection sessions may be performed in each spinal region in a rolling 12-month period regardless of the type of approach (transforaminal, interlaminar, or caudal) or the number of levels involved.
- If the initial injection does not result in pain relief or achieves a suboptimal pain response (less than 50% pain relief) in newly diagnosed patients, a one-time second injection may be performed no sooner than 2 weeks following the initial injection. This second injection is exclusive of the 12-month limit.
- No more than two (2) transforaminal injections may be performed at a single setting (e.g., single level bilaterally or two levels unilaterally). Injecting one level bilaterally would be considered two injections. Injecting two levels, each unilaterally, would also be considered two injections.
- For caudal or cervical/thoracic/lumbar interlaminar injections, only one injection per session may be performed and NOT in conjunction with a transforaminal injection. A session is defined as all epidural steroid injections or spinal procedures performed on a single day.
- Epidural injections should not be combined with any other procedure on spine except under special circumstances such as presence of a large facet joint synovial cyst or large effusion compressing a spinal nerve root in which case a transforaminal injection combined with an intraarticular facet synovial cyst aspiration and steroid injection may be given together.
- After three (3) injections in the same region, the total cumulative dose of steroid must be documented and may not exceed 240 mg of methylprednisolone or triamcinolone, 36 mg of betamethasone, or 45 mg of dexamethasone.
- This guideline does not apply when epidural injections (without any corticosteroid injectate) are used for postoperative pain management.
- This guideline does not apply when epidural injection is used for an implantable infusion pump trial.

## Therapeutic Epidural Steroid Injection (Interlaminar, Caudal, Transforaminal)

Therapeutic epidural steroid injection of the cervical, thoracic, or lumbar spine may be considered medically necessary when **ALL** of the following criteria are met:

- Significant radicular pain (corresponding to a specific dermatomal distribution with or without paresthesia, numbness or weakness), radiculopathy (cervical, thoracic, or lumbar), or neurogenic claudication (lumbar) with associated functional impairment and completed physical exam
- Evidence of **EITHER of the following** is seen on an advanced imaging study* (MRI or CT) and correlates with the clinical findings:
    - Nerve root compression secondary to herniated disc (advanced imaging should be performed within the previous 18 months)
    - Spinal stenosis (central, lateral recess, foraminal, extraforaminal)
- The radicular pain has not responded to at least 4 weeks of appropriate conservative management, unless there is clear evidence of radiculopathy**, in which case epidural steroid injection may be performed following 2 weeks of conservative management

** The initial epidural injection for a given episode of pain in the lumbar spine may be performed without confirmatory advanced imaging if the reported symptoms and exam findings are clearly diagnostic of nerve root compression or spinal stenosis.*

*** Clear evidence of radiculopathy is defined as pain distributed along specific nerve root with corresponding sensory changes, muscle weakness, and, where applicable, positive nerve root irritation sign.*

## Repeat Therapeutic Epidural Steroid Injection

*An injection is considered a repeat injection if the last injection was performed within the previous 12 months. If 12 months or more have elapsed, it is considered a new (initial) injection.*

Repeat therapeutic epidural steroid injection may be considered medically necessary when **ALL** of the following criteria are met:

- Significant radicular pain, radiculopathy (cervical, thoracic, or lumbar), or neurogenic claudication (lumbar) with associated functional impairment
- The prior injection produced at least a 50% reduction in pain with functional improvement of at least 3 months' duration as documented in a follow-up evaluation
- Confirmed evidence demonstrated on advanced imaging (MRI or CT) which correlates with the clinical findings. For herniated nucleus pulposus (HNP), advanced imaging should be performed within the previous 18 months of current request. This imaging requirement is waived for repeat injection if previously satisfied for the initial injection of **EITHER** of the following:
    - Nerve root compression secondary to herniated disc
    - Spinal stenosis (central, lateral recess, foraminal, or extraforaminal)
- The patient continues to receive conservative management between injections

## Diagnostic Selective Nerve Root Block

Diagnostic selective nerve root block (SNRB) is defined as the injection of local anesthetic only, for the purpose of determining the need for surgical intervention.

Diagnostic selective nerve root block may be considered medically necessary in the evaluation and diagnostic workup of radicular pain when **ALL** of the following criteria are met:

- Presence of significant radicular pain or radiculopathy (cervical, thoracic, or lumbar) with associated functional impairment.
- The pain has not responded to at least 4 weeks of appropriate conservative management
- Surgery is being considered and documented by appropriate surgical consult in **ANY** of the following scenarios:
    - To confirm nerve root compression noted on an advanced imaging study (MRI or CT) and that is consistent with, and appears to be contributing to, the patient's symptoms.
    - To determine or confirm the (or most) symptomatic level (i.e., site of compression) in the presence of multi-level involvement for which the primary symptomatic level is unclear.
    - When radiculopathy is highly suspected but cannot be confirmed with advanced imaging studies.

# Contraindications

The following conditions should prompt further evaluation prior to considering epidural steroid injection:

- New onset of low back pain or neck pain in the setting of established malignancy, or where there is a suspicion of malignancy based on the clinical presentation
- New onset of low back pain or neck pain in persons with risk factors for spinal infection or osteoporotic fracture
- Comorbid conditions associated with increased risk of bleeding due to coagulopathy or treatment with anticoagulants
- Back pain in the setting of trauma

Additional contraindications include the following known or suspected conditions:

- Cauda equina syndrome
- Conus medullaris syndrome

- Epidural hematoma
- Epidural abscess
- Epidural mass
- Subarachnoid hemorrhage
- Spinal cord ischemia
- Spinal fracture which occurred less than 6 weeks prior to injection
- Demyelinating disease or other CNS processes which predispose to transverse myelitis
- Systemic infection
- Local infection at the injection site
- Uncontrolled diabetes

## Exclusions

Indications other than those addressed in this guideline are considered **not medically necessary** including, but not limited to the following:

- Moderate-to-severe myelopathy on clinical exam
- Myelopathy associated with intramedullary cord signal change on T1 or T2 weighted MRI
- Isolated axial neck pain, mid-back pain, or low back pain
- Intradiscal spinal injections (including but not limited to chymopapain, collagenase, chondroitin sulfate ABC endolyase, condoliase, and oxygen-ozone) for chemonucleolysis
- Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance, subarachnoid or epidural
- Diagnostic selective nerve root block at more than one level in one session
- More than two sessions for selective nerve root block
- Combined multiple spinal injections regardless of spinal region (e.g., epidural and facet injections) in a single session (except under special circumstances such as presence of a large facet joint synovial cyst compressing a spinal nerve root, in which case a transforaminal injection combined with an intraarticular facet synovial cyst aspiration and steroid injection may be given together)
- Epidural steroid injections performed with biologics or other substances not FDA approved or conditionally approved for this use

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## Codes

The following code list is not meant to be all-inclusive. Authorization requirements will vary by health plan. Please consult the applicable health plan for guidance on specific procedure codes.

Medical necessity reviews are initiated by submitting the correct AMA CPT codes. Specific CPT codes for services should be used when available. The submitted codes must accurately identify the service or procedure to be performed. If no such code exists, contact the health plan directly and report the service or procedure using the appropriate unlisted procedure or Not Otherwise Classified (NOC) code (which often ends in 99). Do not

 

submit a code that is “close to” the procedure performed in lieu of an unlisted code. Correct coding demands that the code reported is appropriate for the service provided (i.e., a code that most accurately represents the service provided), and not a code that is similar but represents another service. (*CPT® Assistant,* December 2010) Nonspecific or NOC codes may be subject to additional documentation requirements and review.

**Note: Preauthorization is required for notification purposes only (medical necessity review is not required) when CPT 62320 and 62322 are used for postprocedural pain with any of the following ICD-10-CM diagnoses: G89.11 Acute pain due to trauma, G89.12 Acute post-thoracotomy pain, or G89.18 Other acute post procedural pain.*

### CPT/HCPCS



| | |
|---|---|
| 62280 | Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; subarachnoid |
| 62281 | Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic |
| 62282 | Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal) |
| 62292 | Injection procedure for chemonucleolysis, including discography, intervertebral disc, single or multiple levels, lumbar |
| 62320* | Injection(s), of diagnostic or therapeutic substance(s) (eg, 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 |
| 62321 | Injection(s), of diagnostic or therapeutic substance(s) (eg, 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 (ie, fluoroscopy or CT) |
| 62322* | Injection(s), of diagnostic or therapeutic substance(s) (eg, 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) (eg, 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 (ie, fluoroscopy or CT) |
| 62324 | Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance |
| 62325 | Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT) |
| 62326 | Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance |
| 62327 | Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, 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 |
| 64480 | Injection(s), anesthetic agent(s) and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure) |
| 64483 | Injection(s), anesthetic agent(s) and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level |
| 64484 | Injection(s), anesthetic agent(s) and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure) |

# Paravertebral Facet Injection/Medial Branch Nerve Block/Neurolysis

## Description

Paravertebral facet joints, also referred to as zygapophyseal joints or Z-joints, have been implicated as a source of chronic neck and low back pain with a prevalence of up to 70% in the cervical spine, and up to 30% in the lumbar spine. Neither physical exam nor imaging has adequate diagnostic power to confidently identify the facet joint as a pain source. Facet joint injection techniques have evolved primarily as a diagnostic tool for pain originating in these joints but have been widely utilized to treat chronic pain shown to be of facet origin.

Injections may be performed at one of two sites, either the joint itself (intra-articular injection) or the nerve that supplies it (medial branch of the dorsal ramus of segmental spinal nerves). Diagnostic injections are performed with an anesthetic agent alone, while therapeutic injections involve administration of a corticosteroid, with or without an anesthetic. Following confirmation of facet pathology using a diagnostic medial branch block, select patients may undergo a radiofrequency nerve ablation procedure. Studies have validated the efficacy of this intervention in chronic pain of facet origin.

## Clinical Indications

*The following general requirements apply to all indications except where they differ from the specific requirements. The specific requirements take precedence over any stated general requirement.*

### General Information

The terms in the section provide operational definitions when they are referenced as requirements in the guideline.

Documentation supporting medical necessity should be submitted at the time of the request and must include the following components:

**Conservative management**[1] should include a combination of strategies to reduce inflammation, alleviate pain, and correct underlying dysfunction, including physical therapy **AND** at least one complementary conservative treatment strategy.

- **Physical therapy requirement** includes **ANY** of the following:
    - Physical therapy rendered by a qualified provider of physical therapy services
    - Supervised home treatment program that includes **ALL** of the following:
        - Participation in a patient specific or tailored program
        - Initial active instruction by MD/DO/PT with redemonstration of patient ability to perform exercises
        - Compliance (documented or by clinician attestation on follow-up evaluation)
    - Exception to the physical therapy requirement in unusual circumstances (for instance, intractable pain so severe that physical therapy is not possible) when clearly documented in the medical record
- **Complementary conservative treatment** requirement includes **ANY** of the following:
    - Anti-inflammatory medications and analgesics[2]
    - Adjunctive medications such as nerve membrane stabilizers or muscle relaxants[2]

- Alternative therapies such as acupuncture, chiropractic manipulation, massage therapy, activity modification, and/or a trial period of rest (e.g., from the aggravating/contributing factors) where applicable

[1] Additional condition or procedure-specific requirements may apply and can be found in the respective sections of the guideline.

[2] In the absence of contraindications

**Clinical reevaluation**. In most cases, reevaluation should include a physical examination. Direct contact by other methods, such as telephone communication or electronic messaging, may substitute for in-person evaluation when circumstances preclude an office visit.

**Failure of conservative management** requires **ALL** of the following:

- Patient has completed a full course of conservative management (as defined above) for the current episode of care
- Worsening of or no significant improvement in signs and/or symptoms upon clinical reevaluation
- More invasive forms of therapy are being considered

Documentation of compliance with a plan of therapy that includes elements from these areas is required where conservative management is appropriate.

**Reporting of symptom severity**: Severity of pain and its associated impact on activities of daily living (ADLs) and instrumental ADLs (IADLs) are key factors in determining the need for intervention. For purposes of this guideline, significant pain and functional impairment refer to pain that is at least 3 out of 10 in intensity and is associated with inability to perform at least two (2) ADLs and/or IADLs.

**Imaging studies**: All imaging must be performed and read by an independent radiologist. If discrepancies should arise in the interpretation of the imaging, the radiology report will supersede. The results of all imaging studies should correlate with the clinical findings in support of the requested procedure.

### Patient Requirements

Patients must meet **ALL** of the following criteria:

- Moderate-to-severe pain with functional impairment of at least 3 months' duration
- Predominant axial pain that is not attributable to radiculopathy (with the exception of facet joint synovial cysts), myelopathy, or neurogenic claudication
- Physical exam findings which are consistent with the facet joint as the presumed source of pain
- Absence of non-facet pathology that could explain the source of the patient's pain, such as fracture, tumor, or infection
- Absence of prior surgical fusion at the proposed level
- Lack of improvement or resolution after completing at least 6 weeks of conservative management for the current condition or episode of pain

### Procedural Requirements

Procedures must be performed with image guidance, either fluoroscopy or CT.

An anatomic spinal region for paravertebral facet joint block (diagnostic or therapeutic) is defined as cervical (CPT codes 64490, 64491, 64492) or lumbar (CPT codes 64493, 64494, 64495).

## Diagnostic Medial Branch Blocks with Local Anesthetic

The primary utility of medial branch blocks (MBB) is to determine the suitability of the patient for a radiofrequency neurotomy of painful segmental levels in order to achieve long-term pain management. A positive response is

defined as at least 80% relief of the primary (index) pain, with the onset and duration of relief being consistent with the agent employed.

*Note: The patient must be experiencing pain at the time of the injection (generally rated at least 3 out of 10 in intensity) in order to determine whether a response has occurred. Provocative maneuvers or positions which normally exacerbate index pain should also be assessed and documented before and after the procedure. Diagnostic medial branch blocks are to be performed with local anesthetic agents only. The concurrent use of steroids is not medically necessary, as it may compromise the integrity of the diagnostic test.*

- Dual medial branch blocks, defined as injections performed in the same location(s) on two separate occasions at least one week apart, are necessary to confirm the diagnosis due to the unacceptably high false positive rate of single medial branch block injections.
- A confirmatory injection is considered medically necessary only if the first injection results in a positive response (defined as at least 80% or more relief in primary pain index). If the second injection also results in a positive response, the target joint(s) is/are the confirmed pain generator(s).
- For each covered spinal region, a maximum of four (4) diagnostic joint sessions are considered medically reasonable and necessary per rolling 12 months, in recognition that the pain generator cannot always be identified with the initial and confirmatory diagnostic procedure.
- A maximum of only 2 diagnostic sessions per level given on separate occasions are appropriate and medically necessary for determination of the patient's candidacy for radiofrequency ablation in a given year (cervical or lumbar).
- For each covered spinal region (cervical or lumbar), diagnostic medial branch blocks may be performed at a maximum of two (2) levels, either unilateral or bilateral, per session.
- A single or dual diagnostic medial branch block may be considered medically necessary for confirming a pars defect as the primary pain generator for low back pain (except in isolated pars defects in young athletes). Documentation of planned surgery or surgical consultation is required.

## Therapeutic Intraarticular Facet Joint Injections

Therapeutic intraarticular facet injections are generally considered **not medically necessary** for facetogenic axial low back pain. The preferred approach is thermal radiofrequency nerve ablation after positive dual diagnostic medial branch blocks. However, an exception for therapeutic intraarticular facet injections may be considered medically necessary when **ALL** Patient Requirements for facet injections are met **AND ANY** of the following conditions (1-4) are documented:

1. There is suspected inflammatory facetogenic pain due to systemic inflammatory arthropathies clearly documented in the patient's history and assessment (e.g., rheumatoid arthritis)
2. Denervation is contraindicated (e.g., young person in whom denervation may result in muscle atrophy that can adversely impact their condition (e.g., spondylolisthesis) or ADLs)
3. Individuals at risk for complications with radiofrequency neurotomy (RFN) treatment (e.g., pacemaker-dependent patients and those with automatic implantable cardioverter-defibrillators, presence of another electronic device such as a spinal cord stimulator or an intrathecal infusion device, older individuals on anticoagulation therapy, presence of surgical hardware)

**For the exceptions listed above only:**

- Therapeutic facet joint injection at the same anatomic site for recurrent pain may be repeated if the prior injection provided at least 50% reduction in pain with functional improvement of at least 3 months duration
- For each covered spinal region, a maximum of four (4) therapeutic facet joint (IA) sessions are considered medically reasonable and necessary per rolling 12 months
- For each covered spinal region (cervical or lumbar), therapeutic facet joint injection may be performed at a maximum of two (2) levels, either unilateral or bilateral, per session.

4. Evidence of nerve root compression due to a facet synovial cyst or large effusion. Patients must meet **ALL** of the following criteria to receive therapeutic intraarticular (IA) facet joint injection:
    - Evidence of nerve root compression due to a facet synovial cyst/large effusion when seen on an advanced imaging study (MRI or CT) performed within the previous 12 months that correlates with the clinical findings
    - Associated moderate-to-severe radicular pain and functional limitations
    - Cyst aspiration/rupture may be repeated once within the 12-month period and only if there is consistent pain reduction of 50% or more for a minimum of three (3) months

The use of therapeutic intraarticular facet injections is considered **not medically necessary** for all other indications.

## Thermal Medial Branch Radiofrequency Neurotomy

- Medial branch radiofrequency neurotomy (RFN) may be offered to patients if dual diagnostic medial branch block injections (with local anesthetic only without any steroids), performed within the last 6 months, each produce at least 80% relief of the primary (index) pain and the onset and minimum duration of relief is consistent with the local anesthetic agent employed.
- Radiofrequency neurotomy may be performed at the same level no more than twice annually and only if the initial radiofrequency lesion results in significant pain relief (at least 50%) and improvement in patient specific ADLs for at least 6 months.
- For each covered spinal region (cervical or lumbar), radiofrequency neurotomy may be performed at a maximum of two (2) levels, either unilateral or bilateral, per session.
- Repeat radiofrequency neurotomy to treat recurrent facet joint pain in a patient who has failed other conservative measures may be considered medically necessary without repeating diagnostic medial branch block injections if the patient has experienced significant and prolonged relief of pain (at least 50% reduction for at least 6 months) and improvement of function in the past following radiofrequency ablation. One confirmatory diagnostic medial branch block may be indicated but not necessary to confirm the same involved facet level.
- For each covered spinal region, a maximum of two (2) radiofrequency sessions are considered medically reasonable and necessary per rolling 12 months.
- Radiofrequency neurotomy may not be performed at C0-C1 or at C1-C2.

## Intraosseous Basivertebral Nerve Ablation

Thermal destruction of the lumbar intraosseous basivertebral nerve (BVN) may be considered medically necessary for the treatment of select chronic low back pain in patients who meet **ALL** the following criteria:

- Skeletally mature patient
- History of chronic lumbar back pain for at least 6 months with a minimum VAS score of ≥ 4 on most days
- Associated significant functional impairment as measured by an ODI ≥ 30
- Documented failure to respond to at least 6 consecutive months of non-surgical management
- All other possible pain sources including, but not limited to, fracture, tumor, infection, or significant spinal deformity have been ruled out
- Imaging studies confirm **BOTH** of the following:
    - Evidence of Modic Type I changes on MRI (i.e., hypointense T1 and hyperintense T2) or Type I and Type II changes on MRI (hyperintense T1 and hyperintense T2) in the endplates of 1 or more vertebrae from L3-S1

    - Absence of non-vertebrogenic pathology that could explain the source of the patient's pain including, but not limited to, fracture, tumor, or infection
- Statement from a primary care physician, neurologist, physiatrist, psychiatrist, psychologist, or other licensed behavioral and/or medical health care provider attesting to the absence of untreated, underlying mental health conditions/issues (e.g., depression, drug abuse, alcohol abuse) as a major contributor to chronic back pain

**Exclusions/Contraindications for Intraosseous BVN Ablation**

- Skeletally immature patients (generally <18 years of age)
- Patients with severe cardiac or pulmonary compromise
- Concurrent vertebral augmentation procedures at the intended levels
- MRI evidence of Modic changes at levels other than L3-S1
- Radicular pain (defined as nerve pain following a dermatomal distribution and that correlates with nerve compression in imaging)
- Previous lumbar spine surgery at the intended treatment level (discectomy/laminectomy allowed if > 6 months prior to baseline and radicular pain resolved)
- Symptomatic spinal stenosis (defined as the presence of neurogenic claudication confirmed by imaging)
- Diagnosed osteoporosis (T-score of -2.5 or less), metabolic bone disease, spine fragility fracture history, or trauma/compression fracture at intended level, or spinal cancer
- Spine infection, active systemic infection, bleeding diathesis
- Radiographic evidence of other pain etiology:
    - Disc extrusion or protrusion > 5 mm at levels L3-S1
    - Spondylolisthesis > 2 mm at any level
    - Spondylolysis at any level
    - Facet arthrosis/effusion correlated with facet-mediated LBP at levels L3-S1
- Current use of extended-release opioids with addiction behaviors
- BMI > 40
- Contraindicated to MRI, allergies to components of the device, or active implantable devices
- Pregnant or lactating women
- Repeat procedure at the same level of a prior intraosseous ablation

## Exclusions

Indications other than those addressed in this guideline are considered **not medically necessary** including, but not limited to the following:

- Diagnostic medial branch block at the same level as a previously successful radiofrequency ablation (RFA) procedure (exception: if there is an extended time (2 years or more) since the last RFA, and/or there is a question as to the source of the recurrent pain, then diagnostic procedures may be repeated)
- Diagnostic intraarticular facet joint injection
- Diagnostic medial branch blocks for reasons other than candidacy for RFA
- Therapeutic medial branch block (use of corticosteroid with diagnostic medial branch block)
- Therapeutic intraarticular facet joint injection for any other indication not listed above

- Diagnostic or therapeutic intraarticular injection, medial branch block, or RFA in the thoracic region with the exception of C7-T1 and T12-L1
- Diagnostic medial branch blocks, therapeutic intraarticular facet joint injections, and radiofrequency neurotomy when performed at C0-C1 or at C1-C2
- Use of medial branch block or radiofrequency neurotomy in the setting of moderate-to-severe spondylolisthesis (grade 3 or higher)
- Use of medial branch block or radiofrequency neurotomy in the setting of an isolated pars defect (except diagnostic medial branch block for pars defect diagnosis presurgical workup)
- Use of medial branch block, intraarticular facet injection, or radiofrequency neurotomy at the level of a prior surgical fusion
- Use of chemical neurolysis for medial branch ablation
- Use of laser neurolysis for medial branch ablation
- Use of open surgical neurolysis
- Use of endoscopic neurolysis or rhizotomy
- Use of cryodenervation (cryoablation) for medial branch ablation
- Use of low-grade thermal energy (less than 80 degrees Celsius) radiofrequency denervation for medial branch ablation
- Use of pulsed radiofrequency denervation for medial branch ablation
- Any facet joint interventions performed under ultrasound guidance
- Intraarticular or extraarticular facet joint prolotherapy, or platelet-rich plasma injection
- Facet joint procedures in more than one spinal region in a single session
- Combined multiple spinal injections regardless of spinal region (e.g., epidural and facet injections) in a single session (except under special circumstances such as presence of a large facet joint synovial cyst compressing a spinal nerve root in which case a transforaminal injection combined with an intraarticular facet synovial cyst aspiration and steroid injection may be given together)

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## Codes

The following code list is not meant to be all-inclusive. Authorization requirements will vary by health plan. Please consult the applicable health plan for guidance on specific procedure codes.

Medical necessity reviews are initiated by submitting the correct AMA CPT codes. Specific CPT codes for services should be used when available. The submitted codes must accurately identify the service or procedure to be performed. If no such code exists, contact the health plan directly and report the service or procedure using the appropriate unlisted procedure or Not Otherwise Classified (NOC) code (which often ends in 99). Do not submit a code that is "close to" the procedure performed in lieu of an unlisted code. Correct coding demands that the code reported is appropriate for the service provided (i.e., a code that most accurately represents the service provided), and not a code that is similar but represents another service. (*CPT® Assistant,* December 2010) Nonspecific or NOC codes may be subject to additional documentation requirements and review.

### CPT/HCPCS



| | |
|---|---|
| 0213T | Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure) |
| 0214T | Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; second level (List separately in addition to code for primary procedure) |
| 0215T | Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure) |
| 0216T | Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; single level |
| 0217T | Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; second level (List separately in addition to code for primary procedure) |
| 0218T | Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure) |
| 64490 | Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophysial) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level |
| 64491 | Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophysial) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure) |
| 64492 | Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure) |
| 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 |
| 64494 | Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure) |
| 64495 | Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure) |
| 64628 | Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first two vertebral bodies lumbar or sacral |
| 64629 | Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral (list separately in addition to code for primary procedure) |
| 64633 | Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint |
| 64634 | Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure) |
| 64635 | Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint |

| | |
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| 64636 | Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure) |

# Regional Sympathetic Nerve Block

## Description

Sympathetic blockade includes procedures that temporarily obstruct the local function of the sympathetic nervous system. Anesthetic is injected directly over the sympathetic neural structures that serve affected limb(s), such as the stellate ganglion or the lumbar sympathetic chain. Radiologic guidance (fluoroscopy or CT scan) is utilized to ensure accuracy.

Regional sympathetic nerve block has been utilized primarily for treatment of complex regional pain syndrome. Despite limited evidence supporting its efficacy, it has also been investigated in treating several other pain syndromes thought to be sympathetically mediated.

This and other interventional procedures should be considered only when the full spectrum of noninvasive management strategies has not provided sufficient relief of symptoms.

## Clinical Indications

*The following general requirements apply to all indications except where they differ from the specific requirements. The specific requirements take precedence over any stated general requirement*.

### General Information

The terms in the section provide operational definitions when they are referenced as requirements in the guideline.

Documentation supporting medical necessity should be submitted at the time of the request and must include the following components:

**Conservative management**[1] should include a combination of strategies to reduce inflammation, alleviate pain, and correct underlying dysfunction, including physical therapy **AND** at least one complementary conservative treatment strategy.

- **Physical therapy requirement** includes **ANY** of the following:
    - Physical therapy rendered by a qualified provider of physical therapy services
    - Supervised home treatment program that includes **ALL** of the following:
        - Participation in a patient specific or tailored program
        - Initial active instruction by MD/DO/PT with redemonstration of patient ability to perform exercises
        - Compliance (documented or by clinician attestation on follow-up evaluation)
    - Exception to the physical therapy requirement in unusual circumstances (for instance, intractable pain so severe that physical therapy is not possible) when clearly documented in the medical record
- **Complementary conservative treatment** requirement includes **ANY** of the following:
    - Anti-inflammatory medications and analgesics[2]
    - Adjunctive medications such as nerve membrane stabilizers or muscle relaxants[2]
    - Alternative therapies such as acupuncture, chiropractic manipulation, massage therapy, activity modification, and/or a trial period of rest (e.g., from the aggravating/contributing factors) where applicable

[1] Additional condition- or procedure-specific requirements may apply and can be found in the respective sections of the guideline.

[2] In the absence of contraindications

**Clinical reevaluation**. In most cases, reevaluation should include a physical examination. Direct contact by other methods, such as telephone communication or electronic messaging, may substitute for in-person evaluation when circumstances preclude an office visit.

**Failure of conservative management** requires **ALL** of the following:

- Patient has completed a full course of conservative management (as defined above) for the current episode of care
- Worsening of or no significant improvement in signs and/or symptoms upon clinical reevaluation
- More invasive forms of therapy are being considered

Documentation of compliance with a plan of therapy that includes elements from these areas is required where conservative management is appropriate.

**Reporting of symptom severity**: Severity of pain and its associated impact on activities of daily living (ADLs) and instrumental ADLs (IADLs) are key factors in determining the need for intervention. For purposes of this guideline, significant pain and functional impairment refer to pain that is at least 3 out of 10 in intensity and is associated with inability to perform at least two (2) ADLs and/or IADLs.

**Imaging studies**: All imaging must be performed and read by an independent radiologist. If discrepancies should arise in the interpretation of the imaging, the radiology report will supersede. The results of all imaging studies should correlate with the clinical findings in support of the requested procedure.

### Procedural Requirements

Procedures must be performed with image guidance, either fluoroscopy or CT.

## Complex Regional Pain Syndrome (Type I or Type II)

Diagnostic criteria for complex regional pain syndrome (CRPS) must be met:

- Continuing pain that is disproportionate to any inciting event
- At least **ONE** symptom reported in at least THREE (3) of the following categories:
    - Sensory: hyperesthesia or allodynia
    - Vasomotor: temperature asymmetry, skin color changes, skin color asymmetry
    - Sudomotor/Edema: edema, sweating changes, or sweating asymmetry
    - Motor/Trophic: decreased range of motion, motor dysfunction (e.g., weakness, tremor, dystonia), or trophic changes (e.g., hair, nail, skin)
- At least **ONE** sign at time of evaluation in at least TWO (2) of the following categories:
    - Sensory: evidence of hyperalgesia (to pinprick), allodynia (to light touch, temperature sensation, deep somatic pressure, or joint movement)
    - Vasomotor: evidence of temperature asymmetry (>1°C), skin color changes or asymmetry
    - Sudomotor/Edema: Evidence of edema, sweating changes, or sweating asymmetry
    - Motor/Trophic: evidence of decreased range of motion, motor dysfunction (e.g., weakness, tremor, dystonia), or trophic changes (e.g., hair, nail, skin)
    - No other diagnosis better explaining the signs and symptoms
- In addition, **ALL** of the following are required:

    - Level of pain and disability in the moderate-to-severe range
    - Failure of at least 2 weeks of conservative management
    - Documentation of ongoing participation in a comprehensive pain management program
    - Procedure must be performed unilaterally

The performance of an initial **diagnostic regional sympathetic block** is considered medically necessary to establish the presence or absence of sympathetically mediated complex regional pain syndrome. A positive response is defined as a significant reduction in pain (at least 80% reduction for at least the duration of the injected local anesthetic) and improvement in function with the duration of relief being consistent with agent employed, and objective evidence that the block was physiologically effective.

For procedures that target pain in a limb, there must be documentation of a rise in temperature of at least 2 degrees Celsius from baseline of the ipsilateral limb. A sensory exam is required to confirm absence of spread to adjacent nerve roots leading to a somatic sensory block.

Following a positive response to the initial diagnostic block, additional therapeutic regional sympathetic blocks, up to maximum of six (6) total blocks, performed at a frequency of no more than two (2) per week, may be considered medically necessary when **ALL** the following criteria have been met:

- Benefit has been demonstrated by prior blocks as evidenced by **ALL** of the following:
    - Decreased use of pain medication
    - Improved level of function (e.g., increased range of motion, strength, and use of extremity in activities of daily living)
    - Improved tolerance to touch (e.g., decreased allodynia) or other objective measures
- The intervention is being provided as part of a comprehensive pain management program (physical therapy, patient education, psychosocial support, and oral medication)
- Maximum six (6) blocks per lifetime

## Exclusions

Indications other than those addressed in this guideline are considered **not medically necessary** including, but not limited to the following:

- Use of sympathetic block CPT code for blocks other than stellate ganglion block and lumbar sympathetic block (e.g., ganglion impar block)
- Only one unilateral sympathetic block per session (stellate ganglion block cannot be performed on same day as lumbar sympathetic block)

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4. Zernikow BW, J.; Brehmer, H.; Hirschfeld, G.; Maier, C. Invasive treatments for complex regional pain syndrome in children and adolescents: a scoping review. Anesthesiology. 2015;122(3):699-707.

 

# Codes

The following code list is not meant to be all-inclusive. Authorization requirements will vary by health plan. Please consult the applicable health plan for guidance on specific procedure codes.

Medical necessity reviews are initiated by submitting the correct AMA CPT codes. Specific CPT codes for services should be used when available. The submitted codes must accurately identify the service or procedure to be performed. If no such code exists, contact the health plan directly and report the service or procedure using the appropriate unlisted procedure or Not Otherwise Classified (NOC) code (which often ends in 99). Do not submit a code that is “close to” the procedure performed in lieu of an unlisted code. Correct coding demands that the code reported is appropriate for the service provided (i.e., a code that most accurately represents the service provided), and not a code that is similar but represents another service. (*CPT® Assistant,* December 2010) Nonspecific or NOC codes may be subject to additional documentation requirements and review.

### CPT/HCPCS



| | |
|---|---|
| 64510 | Injection, anesthetic agent; stellate ganglion (cervical sympathetic) |
| 64520 | Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic) |

# Sacroiliac Joint Injection

## Description

Noninflammatory sacroiliac (SI) joint complex pain may be traumatic, degenerative, or due to adjacent segment disease (after lumbar fusion or total hip replacement). Sacroiliitis is associated with inflammatory spondyloarthropathies. Pain arising from the sacroiliac joint complex typically radiates to the gluteal area and posterior hip. In addition to localized tenderness over the sacroiliac joint, there are additional examination maneuvers which suggest the diagnosis.

## Clinical Indications

*The following general requirements apply to all indications except where they differ from the specific requirements. The specific requirements take precedence over any stated general requirement.*

### General Information

The terms in the section provide operational definitions when they are referenced as requirements in the guideline.

Documentation supporting medical necessity should be submitted at the time of the request and must include the following components:

**Conservative management**[1] should include a combination of strategies to reduce inflammation, alleviate pain, and correct underlying dysfunction, including physical therapy **AND** at least one complementary conservative treatment strategy.

- **Physical therapy requirement** includes **ANY** of the following:
    - Physical therapy rendered by a qualified provider of physical therapy services
    - Supervised home treatment program that includes **ALL** of the following:
        - Participation in a patient specific or tailored program
        - Initial active instruction by MD/DO/PT with redemonstration of patient ability to perform exercises
        - Compliance (documented or by clinician attestation on follow-up evaluation)
    - Exception to the physical therapy requirement in unusual circumstances (for instance, intractable pain so severe that physical therapy is not possible) when clearly documented in the medical record
- **Complementary conservative management requirement** includes **ANY** of the following:
    - Complementary alternative medicine including, but not limited to, chiropractic care, acupuncture, cognitive behavioral or massage therapy
    - Anti-inflammatory medications and analgesics
- **Complementary conservative treatment** requirement includes **ANY** of the following:
    - Anti-inflammatory medications and analgesics[2]
    - Adjunctive medications such as nerve membrane stabilizers or muscle relaxants[2]
    - Alternative therapies such as acupuncture, chiropractic manipulation, massage therapy, activity modification, and/or a trial period of rest (e.g., from the aggravating/contributing factors) where applicable

[1] Additional condition or procedure-specific requirements may apply and can be found in the respective sections of the guideline.

[2] In the absence of contraindications

**Clinical reevaluation**. In most cases, reevaluation should include a physical examination. Direct contact by other methods, such as telephone communication or electronic messaging, may substitute for in-person evaluation when circumstances preclude an office visit.

**Failure of conservative management** requires **ALL** of the following:

- Patient has completed a full course of conservative management (as defined above) for the current episode of care
- Worsening of or no significant improvement in signs and/or symptoms upon clinical reevaluation
- More invasive forms of therapy are being considered

Documentation of compliance with a plan of therapy that includes elements from these areas is required where conservative management is appropriate.

**Reporting of symptom severity**: Severity of pain and its associated impact on activities of daily living (ADLs) and instrumental ADLs (IADLs) are key factors in determining the need for intervention. For purposes of this guideline, significant pain and functional impairment refer to pain that is at least 3 out of 10 in intensity and is associated with inability to perform at least two (2) ADLs and/or IADLs.

**Imaging studies**: All imaging must be performed and read by an independent radiologist. If discrepancies should arise in the interpretation of the imaging, the radiology report will supersede. The results of all imaging studies should correlate with the clinical findings in support of the requested procedure.

### Patient Requirements

Patients must meet **ALL** of the following criteria to be able to proceed with diagnostic intra-articular sacroiliac joint injections or therapeutic intra-articular sacroiliac joint injections.

- There is persistent typically unilateral non-radicular pain that is predominantly below the lumbar spine (L5) and is primarily localized over the region of the sacroiliac joint and has been present for at least 3 months
- Examination shows localized tenderness with palpation over the sacral sulcus just inferior to the posterior superior iliac spine (PSIS) in the absence of tenderness of equal severity elsewhere (e.g., lumbar spine, greater trochanter, hip, coccyx)
- At least **ONE** of the following provocative tests is positive: pelvic distraction test, lateral iliac compression test, sacral compression/thrust test, thigh thrust test, FABER (Patrick's test), and Gaenslen's test
- There is no evidence of acute or subacute radicular pain/radiculopathy or neurogenic claudication. If there is evidence of radicular pain/radiculopathy or neurogenic claudication, the condition must be addressed, stable and have been maximally optimized through comprehensive treatment prior to sacroiliac joint interventions
- Lack of adequate improvement following 6 weeks of conservative management

### Procedural Requirements

Procedures must be performed with image guidance, either fluoroscopy or CT.

## Sacroiliac Joint Injections

### Diagnostic intraarticular sacroiliac joint injections

The primary utility of diagnostic intraarticular sacroiliac joint injections (anesthetic only) is to determine if the sacroiliac joint is the primary pain generator for the patient's low back pain in anticipation of a planned surgical

fusion of the sacroiliac joint only. *The patient's pain level should be obtained prior to injection to accurately determine response. If there are provocative activities associated with the patient's pain, the individual can engage in such activities prior to and after the injection to aid in diagnosis.*

- A second confirmatory injection is considered medically necessary only if the first injection produces at least 75% relief of the primary (index) pain and the onset and minimum duration of relief is consistent with the local anesthetic agent employed. This confirmatory block confirms the tested sacroiliac joint as the source if the index pain is reduced by at least 75% and the onset and minimum duration of relief is consistent with the local anesthetic agent employed.
- Anesthetic volume must be limited to 1.5 cc to maximize the anatomic specificity of the procedure. Concurrent injection of steroid is not appropriate for diagnostic sacroiliac joint injection.* Concurrent injection in any other areas of the spine is also not appropriate for the same reason.
- On the day of the procedure, the patient's pain must be at least 3 out of 10 in severity at rest or during a consistently provocative maneuver, which will allow accurate monitoring of the response to the injection.
- A maximum of only 2 diagnostic unilateral (same side) intraarticular injections given on two separate occasions are appropriate and medically necessary for the determination of the patient's candidacy for surgical fusion (see above).

### Therapeutic intraarticular sacroiliac joint injections

- Therapeutic intraarticular sacroiliac joint injections are performed with the use of corticosteroid with or without the use of anesthetic
- Total injection volume should be limited to 2.0 cc to minimize extra-articular spread of the injectate outside of the sacroiliac joint

**Note: Patients who undergo SI joint injections of both local anesthetic and corticosteroid should have documented a biphasic response—immediate from the anesthetic and delayed from the steroid.* ***If steroid is administered, patients should be asked to keep a meticulous pain diary for the first 24 hours****.*

### Repeat therapeutic intraarticular sacroiliac joint injections

An injection is considered a repeat injection if the last injection was performed within the previous 12 months. If 12 months or more have elapsed, it is considered a new (initial) injection.

- Repeat injection is considered medically necessary if symptoms recur and the patient has demonstrated at least 50% pain relief, and improvement in patient-specific ADLs, for at least 6 weeks after a previous injection. A repeat physical examination must confirm the source of pain as sacroiliac joint as defined in the initial injection requirements.
- Injections may not be repeated at intervals of less than 3 months, with a maximum of three (3) injections in a 12-month period.
- Treatment with therapeutic injections should be accompanied by participation in an ongoing active rehabilitation program, home exercise program, or functional restoration program.

### Ultrasound guidance

- Ultrasound is the only imaging guidance appropriate for use during pregnancy.

## Exclusions

Indications other than those addressed in this guideline are considered **not medically necessary** including, but not limited to the following:

- Intraarticular sacroiliac joint injections performed on the same day as other spine injection procedures
- Therapeutic intra/periarticular sacroiliac joint injections in a previously fused sacroiliac joint

- Use of corticosteroid with diagnostic intraarticular sacroiliac joint injections
- Diagnostic or therapeutic sacral lateral branch blocks
    - Injection of local anesthetic alone for diagnostic purposes or anesthetic and steroid for therapeutic purposes into the sacral lateral branches innervating the sacroiliac joint
- Radiofrequency ablation sacral lateral branch by any method

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## Codes

The following code list is not meant to be all-inclusive. Authorization requirements will vary by health plan. Please consult the applicable health plan for guidance on specific procedure codes.

Medical necessity reviews are initiated by submitting the correct AMA CPT codes. Specific CPT codes for services should be used when available. The submitted codes must accurately identify the service or procedure to be performed. If no such code exists, contact the health plan directly and report the service or procedure using the appropriate unlisted procedure or Not Otherwise Classified (NOC) code (which often ends in 99). Do not submit a code that is “close to” the procedure performed in lieu of an unlisted code. Correct coding demands that the code reported is appropriate for the service provided (i.e., a code that most accurately represents the service provided), and not a code that is similar but represents another service. (*CPT® Assistant,* December 2010) Nonspecific or NOC codes may be subject to additional documentation requirements and review.

### CPT/HCPCS



| | |
|---|---|
| 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) |
| 64625 | Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography) |
| G0260 | Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography |

# Spinal Cord and Dorsal Root Ganglion Stimulators

## Description

Spinal cord stimulators, also known as dorsal column stimulators (“stimulators”), are implantable devices used to treat chronic pain. Electrodes are surgically placed within the dura mater via laminectomy, or by percutaneous insertion into the epidural space. Low voltage electrical signals are delivered to the dorsal column of the spinal cord in order to override or mask sensations of pain.

The patient’s pain distribution pattern determines the level at which the stimulation lead is placed. The lead may incorporate 4 to 8 electrodes, with 8 electrodes typically used for complex pain patterns, such as bilateral pain or pain extending from the limbs to the trunk or pain affecting multiple nerve roots.

Implantation is typically a two-step process. Initially, the electrode is temporarily implanted in the epidural space, allowing a trial period of stimulation. Once treatment effectiveness is confirmed (defined as at least 50% reduction in pain), the electrodes and radio receiver/transducer are permanently implanted.

Extensive programming of the neurostimulators is often required to achieve optimal pain control.

## Clinical Indications

*The following general requirements apply to all indications except where they differ from the specific requirements. The specific requirements take precedence over any stated general requirement*.

### General Information

The terms in the section provide operational definitions when they are referenced as requirements in the guideline.

Documentation supporting medical necessity should be submitted at the time of the request and must include the following components:

**Conservative management**[1] should include a combination of strategies to reduce inflammation, alleviate pain, and correct underlying dysfunction, including physical therapy **AND** at least one complementary conservative treatment strategy.

- **Physical therapy requirement** includes **ANY** of the following:
    - Physical therapy rendered by a qualified provider of physical therapy services
    - Supervised home treatment program that includes **ALL** of the following:
        - Participation in a patient specific or tailored program
        - Initial active instruction by MD/DO/PT with redemonstration of patient ability to perform exercises
        - Compliance (documented or by clinician attestation on follow-up evaluation)
    - Exception to the physical therapy requirement in unusual circumstances (for instance, intractable pain so severe that physical therapy is not possible) when clearly documented in the medical record
- **Complementary conservative treatment** requirement includes **ANY** of the following:
    - Anti-inflammatory medications and analgesics[2]
    - Adjunctive medications such as nerve membrane stabilizers or muscle relaxants[2]

    - Alternative therapies such as acupuncture, chiropractic manipulation, massage therapy, activity modification, and/or a trial period of rest (e.g., from the aggravating/contributing factors) where applicable

- **Interventional modalities**
    - Minimally invasive interventional pain procedures such as epidural injections, facet joint procedures, and sympathetic blocks as appropriate

[1] Additional condition or procedure-specific requirements may apply and can be found in the respective sections of the guideline.

[2] In the absence of contraindications

**Clinical reevaluation**. In most cases, reevaluation should include a physical examination. Direct contact by other methods, such as telephone communication or electronic messaging, may substitute for in-person evaluation when circumstances preclude an office visit.

**Failure of conservative management** requires **ALL** of the following:

- Patient has completed a full course of conservative management (as defined above) for the current episode of care
- Worsening of or no significant improvement in signs and/or symptoms upon clinical reevaluation
- More invasive forms of therapy are being considered

Documentation of compliance with a plan of therapy that includes elements from these areas is required where conservative management is appropriate.

**Reporting of symptom severity**: Severity of pain and its associated impact on activities of daily living (ADLs) and instrumental ADLs (IADLs) are key factors in determining the need for intervention. For purposes of this guideline, significant pain and functional impairment refer to pain that is at least 3 out of 10 in intensity and is associated with inability to perform at least two (2) ADLs and/or IADLs.

**Imaging studies**: All imaging must be performed and read by an independent radiologist. If discrepancies should arise in the interpretation of the imaging, the radiology report will supersede. The results of all imaging studies should correlate with the clinical findings in support of the requested procedure.

## Spinal Cord Stimulation

Spinal cord stimulation (including burst, high frequency, and traditional stimulation methods)

### Stimulator Trial

Stimulator trial may be considered medically necessary when **ALL** of the following criteria are met:

- The patient has chronic intractable neuropathic pain of the trunk and/or limbs associated with at least **ONE** of the following conditions:
    - **Lumbosacral arachnoiditis** as documented by high levels of protein in the cerebrospinal fluid and/or imaging (MRI or myelography)
    - **Nerve root injuries** that are post-surgical after a spine surgery (e.g., failed back surgery syndrome [FBSS])
    - **Complex regional pain syndrome (CRPS)**, type I or type II (formerly known as reflex sympathetic dystrophy or causalgia) which meets diagnostic criteria for CRPS (as per Budapest criteria) as outlined in Regional Sympathetic Nerve Blocks
    - **Peripheral diabetic neuropathy (PDN)** when **ALL** of the following criteria are met:
        - Evidence of painful PDN of at least 12 months
        - Lower limb pain intensity of ≥ 5 on the VAS scale

    - Objective evidence for presence of neuropathy and severity: moderate-severe neuropathy on EMG/NCS (electromyography/nerve conduction studies)
    - Confirmation of PDN diagnosis by at least one other specialist (e.g., neurologist)
    - BMI ≤ 35
    - HbA1c ≤ 10%
    - Daily morphine equivalents of 120 mg or less
    - Documented medical clearance as candidate for the procedure
    - Other causes of neuropathy have been ruled out
    - Optimization of medical management (i.e., diabetes, inflammatory/infectious, vitamin/nutritional deficiencies, renal failure, possible Rx drug/iatrogenic, exposure to toxins)
    - Failed trial (or documented intolerance) to multiple pharmacologic agents in at least 2 categories (i.e., antidepressants like duloxetine [Cymbalta], anticonvulsants like gabapentin/pregabalin, topicals like capsaicin, etc.)
    - Absence of upper limb pain intensity of ≥ 3 on a VAS scale
- Severe pain and disability with documented pathology or an objective basis for the pain
- Dorsal column stimulation is being used as a late or last resort after documented failure of at least 6 consecutive months of physician-supervised multimodal conservative management
- Failed trial of regional sympathetic blocks in the case of CRPS
- There is no evidence of existing untreated drug addiction
- The patient has been evaluated by a pain management specialist prior to implantation
- All the facilities, equipment, and professional and support personnel required for the proper diagnosis, treatment training, and follow-up of the patient must be available
- At least one surgical opinion has been obtained to ensure that the patient does not have a surgically correctable lesion (excludes CRPS and PDN)
- Documentation of an evaluation by a licensed mental health provider within 6 months of a stimulator trial request (e.g., a face-to-face assessment with or without psychological questionnaires and/or psychological testing) that confirms no evidence of an inadequately controlled mental health problem (e.g., alcohol or drug dependence, depression, psychosis) that would negatively impact the success of a spinal cord stimulator or contraindicate its placement

A repeat trial is **not medically necessary** if the initial trial failed, unless failure was due to inability to guide the percutaneous stimulator lead to the appropriate level secondary to anatomical abnormalities. In such cases a surgically placed paddle lead may be appropriate.

Spinal cord stimulator trial must be performed with percutaneously placed leads except under certain situations (e.g., a prior fusion or narrow spinal canal complicates a percutaneous lead placement).

## Stimulator Implantation (Permanent)

Stimulator implantation (permanent) may be considered medically necessary when **ALL** of the following criteria are met:

- The patient meets **ALL** of the criteria for a stimulator trial
- A stimulator trial of at least 3 days duration has been performed
- Documented pain reduction and functional improvement following the stimulator trial with at least a 50% reduction of target pain or analgesic medication use, and specific evidence of improved function

### Stimulator Revision or Removal

Stimulator revision or removal may be considered medically necessary when **ANY** of the following criteria are met:

- Stimulator hardware complication including
  - Lead migration
  - Infection
  - Painful generator site
- Stimulator response complications including
  - Loss of effectiveness
  - Patient intolerance
  - Development of new neurologic deficits
- Planned procedure where stimulators may be contraindicated including
  - Magnetic resonance imaging when other indicated tests have been shown to be inconclusive (such as a CT-myelogram, EMG/NCS, plain x-rays with multiple views)
  - Automatic implantable cardioverter defibrillator

## Dorsal Root Ganglion Stimulation

Dorsal root ganglion (DRG) stimulation may be considered medically necessary as an alternative to dorsal column stimulation in patients with moderate-to-severe chronic intractable pain of the lower limbs from CRPS types I or II and who otherwise meet above criteria for spinal cord stimulator trial or implantation.

# Exclusions

Indications other than those addressed in this guideline are considered **not medically necessary** including, but not limited to the following:

- Use of spinal cord stimulation for the treatment of critical limb ischemia to forestall amputation, refractory angina pectoris, heart failure, and cancer-related pain
- Repeat trial of spinal cord stimulation if the initial trial failed
- Replacement of a conventional spinal cord stimulator with a burst, high frequency, or dorsal root ganglion stimulator in the absence of an indication for stimulator removal
- Dorsal root ganglion neurostimulation for any non-CRPS lower extremity indication
- Dorsal root ganglion neurostimulation in patients with CRPS lower extremity who currently have a functioning spinal cord stimulator or who have previously failed spinal cord stimulation therapy
- Simultaneous placement of a dorsal column and dorsal root ganglion stimulator

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# Codes

The following code list is not meant to be all-inclusive. Authorization requirements will vary by health plan. Please consult the applicable health plan for guidance on specific procedure codes.

Medical necessity reviews are initiated by submitting the correct AMA CPT codes. Specific CPT codes for services should be used when available. The submitted codes must accurately identify the service or procedure to be performed. If no such code exists, contact the health plan directly and report the service or procedure using the appropriate unlisted procedure or Not Otherwise Classified (NOC) code (which often ends in 99). Do not submit a code that is “close to” the procedure performed in lieu of an unlisted code. Correct coding demands that the code reported is appropriate for the service provided (i.e., a code that most accurately represents the service provided), and not a code that is similar but represents another service. (*CPT® Assistant,* December 2010) Nonspecific or NOC codes may be subject to additional documentation requirements and review.

### CPT/HCPCS



| | |
|---|---|
| 63650 | Percutaneous implantation of neurostimulator electrode array, epidural |
| 63655 | Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural |
| 63663 | Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed |
| 63664 | Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed |
| 63685 | Insertion or replacement of spinal neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver |
| 63688 | Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array |
| C1767 | Generator, neurostimulator (implantable), nonrechargeable |
| C1820 | Generator, neurostimulator (implantable), with rechargeable battery and charging system |
| C1822 | Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system |
| L8679 | Implantable neurostimulator, pulse generator, any type |
| L8680 | Implantable neurostimulator electrode, each |
| L8682 | Implantable neurostimulator radiofrequency receiver |
| L8683 | Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver |
| L8685 | Implantable neurostimulator pulse generator, single array, rechargeable, includes extension |
| L8686 | Implantable neurostimulator pulse generator, single array, nonrechargeable, includes extension |
| L8687 | Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension |
| L8688 | Implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension |

# History

| Status | Review Date | Effective Date | Action |
|---|---|---|---|
| Revised | 04/15/2024, 01/23/2024, 10/23/2023 | 06/30/2024 | Independent Multispecialty Physician Panel (IMPP) review. Added medical necessity criteria for Intraosseous BVN Ablation and associated CPT codes 64628 and 64629. Added references. |
| Revised | 07/18/2023 | 04/14/2024*<br>*Not for LA Medicaid | IMPP review. Epidural injections: added osteoporotic fracture as a contraindication. Facet injections: added exclusions. Spinal cord/Dorsal root stimulators: expanded stimulator trial criteria for PDN; added clarifications. Added references. Added required language per new Medicare regulations. |
| Updated | n/a | 01/01/2024 | Annual CPT code update. Description changes for 63685 and 63688. Added guidance for correct coding to code section. |
| Revised | 05/09/2022 | 04/09/2023; 06/18/2023 for LA Medicaid | IMPP review. Updated conservative management requirements to align with other Carelon guidelines. Revised criteria for Epidural injections, Diagnostic MBB, RFN, Regional sympathetic nerve block. |
| Revised | 05/09/2022 | 11/06/2022 for commercial, Medicare, non-Anthem Medicaid; 04/09/2023 for Anthem Medicaid except LA; 06/18/2023 for LA Medicaid | IMPP review. Epidural injections: For nerve root compression due to herniated disc, MRI/CT must be done within the previous 18 months. SNRB: Included a second session for cases requiring evaluation of more than one level. Therapeutic intra-articular facet injections: Added criteria for repeat injections in patients who met criteria for an initial injection. Added references. |
| Revised | 05/26/2021 | 03/13/2022 | IMPP review. Epidural Injection Procedures and Diagnostic Selective Nerve Root Blocks (DSNRB): allowed more frequent use in newly diagnosed patients, removed imaging requirement in certain circumstances, added epidural abscess as a contraindication; DSNRBs required similar criteria to ESI and limited multilevel and combination DSNRB. Paravertebral Facet Injection/MBB/Neurolysis: limited indefinite use of diagnostic MBB, defined MBB timing with respect to RFN, MBB limited to RFA candidacy, limited open surgical neurolysis, and limited multiple spinal injections. Sacroiliac Joint Injections: limited indefinite use of diagnostic IA injections, disallowed sacral lateral branch blocks and injections in a previously fused joint. Spinal Cord and Nerve Root Stimulators: allowed minimally invasive pain procedures to satisfy conservative management definition, specified timing of mental health evaluation, defined indications for repeat stimulator trial. Updated references. Removed CPT code 64640. |
| Revised | 05/26/2021 | 11/07/2021 | IMPP review. Epidural Injection Procedures and Diagnostic SNRBs: allowed thoracic injections; removed thoracic ESI exclusion. Moved exclusion for radiofrequency neurolysis and CPT codes 64625 and 64640 from Paravertebral Facet Injection/MBB/ Neurolysis section to SI Joint Injections. Spinal Cord and Nerve Root Stimulators: waived surgical opinion requirement for patients with CRPS. Updated references. |
| Revised | 07/08/2020 | 03/14/2021 | IMPP review. Added exclusions: intradiscal spinal injections for chemonucleolysis, injection/infusion of neurolytic substances into the epidural or subarachnoid space, and diagnostic or therapeutic injection (anesthetic and/or steroid) of nerves innervating the SI joint. Added CPT codes 62280, 62281, 62282, 62292, 62324, 62325, 62327, 64451. |
| Updated | - | 01/01/2021 | 2021 Annual CPT code update: removed 0228T, 0229T, 0230T, 0231T; descriptions changed for 64479, 64480, 64483, 64484. |

| Status | Review Date | Effective Date | Action |
|---|---|---|---|
| Revised | 10/29/2019 | 08/16/2020 | IMPP review. Modified conservative management requirements to include physical therapy or home therapy plus a complementary modality in alignment with AIM [Carelon] Guidelines for Spine Surgery and Joint Surgery. Epidural Injection Procedures and Diagnostic SNRBs: added statement regarding adherence to procedural best practices established by FDA Safe Use Initiative; clarified intent around requirement for advanced imaging for repeat injections. Paravertebral Facet Injection/Nerve Block/Neurolysis: removed indication for four unilateral MBBs per session; limited use of intraarticular steroid injection to mechanical disruption of a facet synovial cyst. Spinal Cord and Nerve Root Stimulators: new indication for dorsal root ganglion stimulation; clarified exclusions for spinal cord and dorsal root ganglion stimulation. |
| Revised | - | 01/01/2020 | 2020 Annual CPT code update: added 64625 (paravertebral facet joint injection/nerve block/neurolysis). |
| Revised | 09/12/2018 | 05/18/2019 | IMPP review. All procedures: Reporting of symptom severity expanded to include instrumental ADLs as functional impairment. Epidural Injection Procedures and Diagnostic SNRBs: updated time period of initial advanced imaging; added definition and frequency of repeat therapeutic ESIs; updated maximum number of annual injections; added criteria for subsequent injection after suboptimal initial response. Sacroiliac Joint Injection: lowered threshold in demonstrated pain reduction from the initial injection. Spinal Cord Stimulators: added criteria for revision/removal of spinal cord stimulator; separated criteria of trial stimulation and permanent stimulator implantation; added exclusion of dorsal root ganglion stimulation. |
| Revised | 09/12/2018 | 01/01/2019 | IMPP review. Paravertebral Facet Injection/Nerve Block/Neurolysis: exclusion added for radiofrequency neurolysis for SI joint pain. 2019 Annual CPT code update: added 0228T, 0229T, 0230T, 0231T (epidural injection procedures); added 0213T, 0214T, 0215T, 0216T, 0217T, 0218T, 64640 (paravertebral facet joint injection/nerve block/neurolysis). HCPCS codes: added C1767, C1820, C1822, L8679, L8680, L8682, L8683, L8685, L8686, L8687, L8688 (spinal cord stimulators). |
| Revised | 07/11/2018 | 03/09/2019 | IMPP review. Added the General Clinical Guideline. |
| Revised | 12/12/2017 | 07/01/2018 | IMPP review. Epidural Injection Procedures and Diagnostic Selective Nerve Root Blocks: added preauthorization exemption for CPT codes 62320 and 62322 when used for post-procedural pain with certain diagnoses; for repeat therapeutic ESIs, clarified initial injection as therapeutic; clarified injection sessions for procedural requirements. Paravertebral Facet Injection/Nerve Block/Neurolysis: increased procedural limitation for diagnostic MBBs; increased procedural limitation for therapeutic intraarticular facet joint injections and clarified requirement for conservative treatment between injections. Added HCPCS code G0260 (SI joint injection). |
| Created | 06/13/2017 | 11/01/2017 | IMPP review. Original effective date. |