2026 Evolent Clinical Guidelines for Medical Necessity Review

INTERVENTIONAL PAIN MANAGEMENT GUIDELINES

Effective July 1, 2026 – July 1, 2027

Guidelines for Clinical Review Determination

Preamble

Evolent is committed to the philosophy of supporting safe and effective treatment for patients. The medical necessity criteria that follow are guidelines for the provision of diagnostic imaging. These criteria are designed to guide both providers and reviewers to the most appropriate diagnostic tests based on a patient's unique circumstances. In all cases, clinical judgment consistent with the standards of good medical practice will be used when applying the guidelines. Determinations are made based on both the guideline and clinical information provided at the time of the request. It is expected that medical necessity decisions may change as new evidence-based 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.

Guideline Development Process

These medical necessity criteria were developed by Evolent for the purpose of making clinical review determinations for requests for therapies and diagnostic procedures. The developers of the criteria sets included representatives from the disciplines of radiology, internal medicine, nursing, cardiology, and other specialty groups. Evolent's guidelines are reviewed yearly and modified when necessary following a literature search of pertinent and established clinical guidelines and accepted diagnostic imaging practices.

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Evolent Clinical Guideline 1750 for Epidural Spine Injections

Guideline Number: Evolent_CG_1750	**Applicable Codes**	
"Evolent" refers to Evolent Health LLC and Evolent Specialty Services, Inc. 		
Original Date: October 2012	**Last Revised Date:** December 2025	**Implementation Date:** July 2026

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STATEMENT

General Information

- *It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *The guideline criteria in the following sections were developed utilizing evidence-based and peer-reviewed resources from medical publications and societal organization guidelines as well as from widely accepted standard of care, best practice recommendations.*

Purpose

This guideline describes indications, contraindications, and exclusions for the performance of epidural spine injections, based on The American Society of Interventional Pain Physicians (ASIPP) recommended algorithmic approach. [1]

Scope

This guideline applies to all licensed participating network practitioners who provide this service.

Special Note

New Episodes of Care

Any injection performed at least two years from prior injections in the same region will be considered a new episode of care and the **initial** injection requirements must be met for approval. Events such as surgery on the same spinal region or any new pathology would also prompt a new episode of care.

INDICATIONS

General to All Caudal, Interlaminar, and Transforaminal Injections

- Fluoroscopic guidance should be used for caudal and interlaminar injections and is necessary for transforaminal injections.
- For all injections, patients must exhibit pain causing functional disability or average pain level of ≥6 on a scale of 0 to 10 [2–4] related to the requested spinal region.

Treatment Purposes

- Acute pain or exacerbation of chronic radicular pain (all the following must be met) [1]:

- Neck or back pain with acute radicular symptoms
- Duration of pain < 3 months
- Failure to respond to non-operative conservative treatment targeting the requested spinal region for a minimum of 2 weeks unless the medical reason this treatment cannot be done is clearly documented (active therapy components not required) [2]

- Spinal stenosis causing axial or radicular pain (all the following must be met) [1]:
  - Failure to respond to non-operative **conservative treatment*** targeting the requested spinal region for a minimum of six (6) weeks in the last six (6) months unless the medical reason this treatment cannot be done is clearly documented
    - **OR** details of engagement in ongoing non-operative conservative treatment if the individual has had prior spinal injections in the same region [3,5]
- Failed back surgery syndrome or epidural fibrosis causing axial or radicular pain (all of the following must be met) [1,6]:
  - Documentation of a medical reason that clearly indicates why an injection is needed (not typically done immediately post-surgery) [3]
- Failure to respond to non-operative **conservative treatment*** targeting the requested spinal region for a minimum of six (6) weeks in the last six (6) months unless the medical reason this treatment cannot be done is clearly documented
  - Failure of conservative treatment is defined as one of the following:
    - Lack of meaningful improvement after a full course of treatment; **OR**
    - Progression or worsening of symptoms during treatment; **OR**
    - Documentation of a medical reason the member is unable to participate in treatment *(Closure of medical or therapy offices, patient inconvenience, or noncompliance without explanation does not constitute "inability to complete" treatment)*
  - **OR** details of engagement in ongoing non-operative **conservative treatment*** if the individual has had prior spinal injections in the same region [2]

Diagnostic Purposes

- Transforaminal injection to identify the pain generator for surgical planning (all the following must be met):
  - Documentation of a pre-operative evaluation and plan for surgery

NOTE: No more than 2 levels of transforaminal blocks should be done in one day.

Repeat Injections

Epidural injections may be repeated only as medically necessary. Each epidural injection requires an authorization, and the following criteria must be met for repeat injections.

Initial Treatment Phase

- Up to 3 epidural injections may be performed in the initial treatment phase, no sooner than 2 weeks apart, provided that at least 30% pain relief or significant documented functional improvement is obtained [4]
    - If an injection during the initial treatment phase is unsuccessful, another injection may be performed at a different level in the **same spinal region** or with a change in technique given there is a question about the pain generator or evidence of multi-level pathology

Therapeutic Phase

- Epidural injections may only be repeated after the initial treatment phase (see above) if the individual has had at least 50% pain relief or significant documented functional improvement for a **minimum of 2 months** before each therapeutic injection [3]
- The patient:
    - continues to have moderate to severe pain causing functional disability or average pain level ≥ 6 on a scale of 0 to 10 related to the requested spinal region. [3,4]
    - is engaged in ongoing active conservative treatment, unless the medical reason this treatment cannot be done is clearly documented
- In the first year of treatment, a total of 6 epidural injections may be performed **per spinal region**
    - (this includes up to 3 injections in the initial treatment phase and 3 additional therapeutic injections). [3]
- After the first year of treatment, a maximum of 4 epidural injections may be performed in a 12-month period **per spinal region**. [3,4]
    - If special circumstances are documented (e.g., elderly individual with severe spinal stenosis and not an operative candidate), then repeat injections are limited to a maximum of 6 epidural injections in a 12-month period per spinal region. [4]
- If different spinal regions are being treated, injections should be administered at intervals of at least 7 days unless a medical reason is provided to necessitate injecting multiple regions on the same date of service (see **Medical Necessity**). [3]

Exclusions

The following requests are excluded from consideration under this guideline:

- Intrathecal injections for pain or spasticity prior to permanent pump insertion
- Implantation of intrathecal catheters or ports for chemotherapy
- Post-operative pain control
- Caudal or spinal anesthesia for surgery

Contraindications

- Active systemic or spinal infection
- Skin infection at the site of needle puncture
- Severe spinal stenosis resulting in intraspinal obstruction

CODING AND STANDARDS

Codes

CPT	
Code	**Description**
Cervical/Thoracic Interlaminar Epidural	
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)
Cervical/Thoracic Transforaminal Epidural	
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)
Lumbar/Sacral Interlaminar Epidural	
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

CPT	
Code	**Description**
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)
Lumbar/Sacral Transforaminal Epidural	
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)

Applicable Lines of Business

☒	CHIP (Children's Health Insurance Program)
☒	Commercial
☒	Exchange/Marketplace
☒	Medicaid
☒	Medicare Advantage

BACKGROUND

Medical Necessity

Medical necessity management for epidural injections includes an initial evaluation including history and physical examination as well as a psychosocial and functional assessment. The following must be determined:

- Nature of the suspected organic problem
- Non-responsiveness to active conservative treatment
- Level of pain and functional disability

- Conditions which may be contraindications to epidural injections
- Responsiveness to prior interventions

NOTE: It is generally considered **not medically necessary** to perform multiple interventional pain procedures on the same date of service. Documentation of a medical reason to perform injections in different regions on the same day can be provided and will be considered on a case-by-case basis (e.g., holding anticoagulation therapy on two separate dates creates undue risk for the patient). Different types of injections in the same spinal region (cervical, thoracic, or lumbar) should not be done on the same day with the exception of a facet injection and epidural steroid injection (ESI) performed during the same session for a synovial cyst confirmed on imaging.

Conservative Treatment*

Non-operative conservative treatment should include a multimodality approach consisting of at least one (1) active and one (1) inactive component targeting the affected spinal region.

- Active Modalities
  - Physical therapy
  - Physician-supervised home exercise program (HEP)**
  - Chiropractic care
- Inactive Modalities
  - Medications (e.g., NSAIDs, steroids, analgesics)
  - Injections (e.g., epidural steroid injection, selective nerve root block)
  - Medical devices (e.g., TENS unit, bracing)

Home Exercise Program (HEP)**

The following two elements are required to meet conservative therapy guidelines for HEP:

- Documentation of an exercise prescription/plan provided by a physician, physical therapist, or chiropractor **AND**
- Follow-up documentation regarding completion of HEP after the required 6-week timeframe or inability to complete HEP due to a documented medical reason (i.e., increased pain or inability to physically perform exercises)

SUMMARY OF ANALYSIS

Epidural Interventions in the Management of Chronic Spinal Pain: American Society of Interventional Pain Physicians (ASIPP) Comprehensive Evidence-Based Guidelines [(1)]**:**

- **Study Design:** This study is a comprehensive review and guideline development based on systematic reviews and randomized controlled trials (RCTs) related to epidural interventions for chronic spinal pain.

- **Target Population:** The target population includes patients with chronic spinal pain in various regions such as lumbar, cervical, and thoracic spine.
- **Key Factors:**
  - **Objective:** To provide evidence-based guidance for performing therapeutic epidural procedures.
  - **Methods:** The study involved developing objective and key questions, reviewing literature, and synthesizing best evidence from 47 systematic reviews and 43 RCTs.
  - **Results:** The guidelines cover various conditions such as disc herniation, spinal stenosis, axial discogenic pain, and post-surgery syndrome, with evidence levels ranging from I to IV based on the quality of studies.
  - **Conclusions:** The guidelines were prepared with a comprehensive review of the literature and methodologic quality assessment, providing recommendations for long-term effectiveness of epidural interventions.

An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations [3]**:**

- **Study Design:** This study involves the development of evidence-based clinical practice guidelines for interventional techniques in diagnosing and treating chronic spinal pain.
- **Target Population:** Patients with chronic spinal pain in the lumbar, cervical, and thoracic spine.
- **Key Factors:**
  - **Objective:** To develop guidelines for interventional techniques in chronic spinal pain management.
  - **Methods:** Systematic assessment of the literature, including diagnostic and therapeutic interventions.
  - **Results:** The evidence for various interventions is categorized as good, fair, or limited. For example, diagnostic lumbar facet joint nerve blocks and sacroiliac intraarticular injections have good evidence, while therapeutic facet joint interventions have varying levels of evidence.
  - **Conclusions:** The guidelines provide recommendations for diagnostic and therapeutic interventions, emphasizing the need for high-quality studies and appropriate evidence synthesis.

Lumbar Transforaminal Epidural Steroid Injections: Review & Recommendation Statement [4]**:**

- **Study Design:** This document is a review and recommendation statement based on a comprehensive literature review of lumbar transforaminal epidural steroid injections (LTFESI).
- **Target Population:** Patients with lumbar radicular pain due to disc herniation or spinal stenosis.
- **Key Factors:**

- **Objective:** To present the current state of evidence for LTFESI in treating lumbar radiculopathy and provide evidence-based recommendations.
- **Methods:** The review includes a systematic assessment of the literature, focusing on prognostic indicators, efficacy, complications, and cost-effectiveness.
- **Results:** LTFESI is recommended for providing relief of radicular pain related to lumbar disc herniation, with evidence supporting its effectiveness for at least one month in more than 50% of patients. The review also highlights the need for careful patient selection and monitoring for complications.
- **Conclusions:** The document provides guidelines for the use of LTFESI, emphasizing the importance of evidence-based practice and the need for further research to clarify the benefits in specific patient groups.

ANALYSIS OF EVIDENCE

Shared Findings:

- **Effectiveness for Radicular Pain**:
  - All three articles agree that epidural spine injections, particularly lumbar transforaminal epidural steroid injections (LTFESI), are effective in providing relief for radicular pain due to lumbar disc herniation. The NASS Lumbar Transforaminal ESI Statement 2013 emphasizes that LTFESI provides significant pain relief for at least one month in more than 50% of patients, with some experiencing relief for a year or more. [4] Manchikanti et al 2021 and Manchikanti et al 2013 also support the use of epidural injections for managing disc herniation and radiculitis. [1,3]
- **Guideline Development**:
  - Both Manchikanti et al 2021 and Manchikanti et al 2013 focus on developing evidence-based clinical practice guidelines for interventional techniques in managing chronic spinal pain. They emphasize the importance of systematic reviews and randomized controlled trials (RCTs) in forming these guidelines. [1,3]
- **Safety and Complications**:
  - The articles acknowledge that while epidural spine injections are generally safe, there are potential risks and complications. The NASS Lumbar Transforaminal ESI Statement 2013 highlights the rare but catastrophic risk of spinal cord injury due to vascular injection of particulate steroids. [4] Manchikanti et al 2021 and Manchikanti et al 2013 also discuss the importance of minimizing risks and adhering to safety guidelines. [1,3]

Differing Findings:

- **Effectiveness for Spinal Stenosis**:
  - The NASS Lumbar Transforaminal ESI Statement 2013 indicates insufficient evidence to make a specific recommendation for the efficacy of LTFESI in treating lumbar radicular pain in the setting of central or foraminal stenosis. [4] In contrast,

Manchikanti et al 2021 and Manchikanti et al 2013 provide fair evidence supporting the use of epidural injections for managing spinal stenosis. [1,3]

- **Long-term Effectiveness**:
  - Manchikanti et al. 2021 provides a comprehensive review of the long-term effectiveness of various epidural interventions, including caudal, interlaminar, and transforaminal injections, with evidence levels ranging from I to IV. [1] The NASS Lumbar Transforaminal ESI Statement 2013 focuses more on the short-term effectiveness of LTFESI, with limited discussion on long-term outcomes. [4]
- **Cost-effectiveness**:
  - The NASS Lumbar Transforaminal ESI Statement 2013 discusses the cost-effectiveness of LTFESI, particularly for patients with contained disc herniations, and suggests that LTFESI is substantially more cost-effective than sham treatment. [4] This aspect is not extensively covered in Manchikanti et al 2021 and Manchikanti et al 2013. [1,3]
- **Analysis of Evidence**
- **Study Design**: All three articles rely on systematic reviews and RCTs to form their conclusions. Manchikanti et al 2021 and Manchikanti et al 2013 provide detailed guidelines based on a comprehensive review of the literature, while the NASS Lumbar Transforaminal ESI Statement 2013 focuses on specific clinical questions related to LTFESI. [1,3,4]
- **Target Population**: The target population across the articles includes patients with chronic spinal pain, lumbar disc herniation, and spinal stenosis. [1,3,4]
- **Key Factors**: The articles emphasize the importance of patient selection, the type of epidural injection, and adherence to safety guidelines to maximize the effectiveness and minimize the risks of epidural spine injections. [1,3,4]

In summary, while there is a consensus on the effectiveness of epidural spine injections for radicular pain due to lumbar disc herniation, there are differing conclusions regarding their effectiveness for spinal stenosis and long-term outcomes. The NASS Lumbar Transforaminal ESI Statement 2013 provides a more focused analysis on LTFESI, [4] including cost-effectiveness, while Manchikanti et al 2021 and Manchikanti et al 2013 offer comprehensive guidelines for various epidural interventions. [1,3]

POLICY HISTORY

Date	Summary
December 2025	• Added CPT code table to reflect new formatting. • Updated General Information, Conservative Care, Legislative Language • Removed Washington State regulatory language.

Date	Summary
	● Added Summary of Evidence and Analysis of Evidence
December 2024	● This guideline replaces Evolent Clinical Guideline 300 for Epidural Spine Injections
January 2024	● Added conservative tx language ● Added legislative language for WA state

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Specialty Services Clinical Guideline Review Committee

Disclaimer

Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. Evolent clinical guidelines contain guidance that requires prior authorization and service limitations. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.

Evolent Clinical Guidelines are comprehensive and inclusive of various procedural applications for each service type. Our guidelines may be used to supplement Medicare criteria when such criteria is not fully established. When Medicare criteria is determined to not be fully established, we only reference the relevant portion of the corresponding Evolent Clinical Guideline that is applicable to the specific service or item requested in order to determine medical necessity.

REFERENCES

1. Manchikanti L, Knezevic NN, Navani A, et al. Epidural Interventions in the Management of Chronic Spinal Pain: American Society of Interventional Pain Physicians (ASIPP) Comprehensive Evidence-Based Guidelines. *Pain Physician*. 2021;24(S1):S27-S208.
2. Kreiner DS, Hwang S, Easa J, Resnick DK. *Clinical Guidelines for Diagnosis and Treatment of Lumbar Disc Herniation with Radiculopathy*. North American Spine Society; 2012.
3. Manchikanti L, Abdi S, Atluri S, et al. An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations. *Pain Physician*. 2013;16(2 Suppl):S49-283. http://www.ncbi.nlm.nih.gov/pubmed/23615883
4. Akuthota V, Bogdok N, Easa JE, et al. Lumbar Transforaminal Epidural Steroid Injections: Review & Recommendation Statement. *NASS*. Published online 2013.
5. Sayed D, Grider J, Strand N, et al. The American Society of Pain and Neuroscience (ASPN) Evidence-Based Clinical Guideline of Interventional Treatments for Low Back Pain. *J Pain Res*. 2022;Volume 15:3729-3832. doi:10.2147/JPR.S386879
6. Orhurhu VJ, Chu R, Gill J. *Failed Back Surgery Syndrome Continuing Education Activity*.

Evolent Clinical Guideline 1751 for Epidural Spine Injections and Single Injection Trials for Intrathecal Pumps

Guideline Number: Evolent_CG_1751	**Applicable Codes**	
"Evolent" refers to Evolent Health LLC and Evolent Specialty Services, Inc. 		
Original Date: May 2022	**Last Revised Date:** December 2025	**Implementation Date:** July 2026

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STATEMENT

General Information

- *It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *The guideline criteria in the following sections were developed utilizing evidence-based and peer-reviewed resources from medical publications and societal organization guidelines as well as from widely accepted standard of care, best practice recommendations.*

Purpose

This guideline describes indications, contraindications, and exclusions for the performance of epidural spine injections, based on The American Society of Interventional Pain Physicians (ASIPP) recommended algorithmic approach, [1] and indications, contraindications and exclusions for single injection intraspinal drug trials for intrathecal pumps.

NOTE: There are no medical indications for intrathecal treatments except chronic pain and intractable spasticity.

Scope

The therapeutic use of epidural injections is for short-term pain relief associated with acute back pain or exacerbation of chronic back pain. With therapeutic injections, a corticosteroid is injected close to the target area with the goal of pain reduction.

An implantable infusion pump (IIP), also referred to as an implantable drug delivery system (IDDS), is a device for the delivery of medication to manage severe, chronic, intractable pain and/or chronic intractable spasm. An intrathecal/intraspinal drug trial utilizes a temporary implant to demonstrate efficacy and appropriateness of an IIP.

Special Note

New Episode of Care

Any injection performed at least two years from prior injections in the same region will be considered a new episode of care and the **INITIAL** injection requirements must be met for approval. Events such as surgery on the same spinal region or any new pathology would also prompt a new episode of care.

INDICATIONS FOR INITIAL EPIDURAL SPINAL INJECTIONS/NERVE BLOCKS

General to all Caudal, Interlaminar and Transforaminal Injections

- Fluoroscopic guidance should be used for caudal and interlaminar injections and is necessary for transforaminal injections.
- For all injections, patients must exhibit pain causing functional disability or average pain level of ≥ 6 on a scale of 0 to 10 [2–4] related to the requested spinal region.

Treatment Purposes

- Acute pain or exacerbation of chronic radicular pain (all the following must be met) [1]:
  - Neck or back pain with acute radicular symptoms
  - Duration of pain < 3 months
  - Failure to respond to non-operative **conservative treatment*** targeting the requested spinal region for a minimum of 2 weeks unless the medical reason this treatment cannot be done is clearly documented (active therapy components not required) [2]
- Spinal stenosis causing axial or radicular pain (all of the following must be met) [1]:
  - Failure to respond to non-operative conservative treatment* targeting the requested spinal region for a minimum of six (6) weeks in the last six (6) months unless the medical reason this treatment cannot be done is clearly documented
    - **OR** details of engagement in ongoing non-operative conservative treatment if the individual has had prior spinal injections in the same region [3,5]
- Failed back surgery syndrome or epidural fibrosis causing axial or radicular pain (all of the following must be met) [1,6]:
  - Documentation of a medical reason that clearly indicates why an injection is needed (not typically done immediately post-surgery) [3]
  - Failure to respond to non-operative **conservative treatment*** targeting the requested spinal region for a minimum of six (6) weeks in the last six (6) months unless the medical reason this treatment cannot be done is clearly documented
    - **OR** details of engagement in ongoing non-operative conservative treatment if the individual has had prior spinal injections in the same region [2]

NOTE: Failure of conservative treatment is defined as one of the following:

- Lack of meaningful improvement after a full course of treatment; **OR**
- Progression or worsening of symptoms during treatment; **OR**
- Documentation of a medical reason the member is unable to participate in treatment

(Closure of medical or therapy offices, patient inconvenience, or noncompliance without explanation does not constitute “inability to complete” treatment)

Diagnostic Purposes [1,4]

- Transforaminal injection to identify the pain generator for surgical planning (all of the following must be met):
  - Documentation of a pre-operative evaluation and plan for surgery

NOTE: No more than 2 levels of transforaminal blocks should be done in one day

Repeat Epidural Spinal Injections

Epidural injections may be repeated only as medically necessary. Each epidural injection requires an authorization, and the following criteria must be met for repeat injections.

Initial Treatment Phase

- Up to 3 epidural injections may be performed in the initial treatment phase, no sooner than 2 weeks apart, provided that at least 30% pain relief or significant documented functional improvement is obtained [4]
  - If an injection during the initial treatment phase is unsuccessful, another injection may be performed at a different level in the **same spinal region** or with a change in technique given there is a question about the pain generator or evidence of multi-level pathology

Therapeutic Phase

- Epidural injections may only be repeated after the initial treatment phase if the individual has had at least 50% pain relief or significant documented functional improvement for a **minimum of 2 months** before each therapeutic injection [3]
- The patient:
  - continues to have pain moderate to severe pain causing functional disability or average pain level ≥ 6 on a scale of 0 to 10 related to the requested spinal region. [3,4]
  - is engaged in ongoing active conservative treatment, unless the medical reason this treatment cannot be done is clearly documented
- In the first year of treatment, a total of 6 epidural injections may be performed **per spinal region**
  - This includes up to 3 injections in the initial treatment phase and 3 additional therapeutic injections. [3]
- After the first year of treatment, a maximum of 4 epidural injections may be performed in a 12-month period **per spinal region**. [3,4]
  - If special circumstances are documented (e.g., elderly individual with severe spinal

stenosis and not an operative candidate), then repeat injections are limited to a maximum of 6 epidural injections in a 12-month period per spinal region. (4)

- If different spinal regions are being treated, injections should be administered at intervals of at least 7 days unless a medical reason is provided to necessitate injecting multiple regions on the same date of service (see **Medical Necessity**). (3)

Contraindications for Epidural Spinal Injections

- Active systemic or spinal infection
- Skin infection at the site of needle puncture
- Severe spinal stenosis resulting in intraspinal obstruction

INDICATIONS FOR INTRASPINAL DRUG TRIAL

Chronic Intractable Pain in Non-Terminal Individuals

For the treatment of chronic intractable pain in non-terminal individuals (**ALL** the following criteria must be met):

- Pain causing functional disability that significantly interferes with activities of daily living, including ability to work and overall quality of life (5) **OR** persistent pain level of ≥ 6 on a scale of 0 to 10 despite treatment
- Failure to respond to non-operative conservative therapy targeting the requested spinal region for a minimum of 12 weeks unless the medical reason this treatment cannot be done is clearly documented

Spasticity in Non-Terminal Individuals

For the treatment of spasticity in non-terminal individuals (**ALL** the following must be met):

- Intractable spasticity that results in the individual's inability to maintain an upright posture, severely impairs balance in ambulation, or significantly interferes with activities of daily living related to **ONE** of the following conditions (7,8):
  - Spinal cord injury
  - Multiple sclerosis
  - Stiff person syndrome
  - Other medical conditions causing intractable spasms
- Failure to respond to a minimum of 12 weeks of non-operative conservative therapy (e.g., oral medications, physical therapy, etc.)

Additional Trials

A second intraspinal drug trial is indicated when documentation of the first trial of intraspinal (intrathecal or epidural) medication administered as a bolus or by continuous infusion resulted in one of the following:

- Less than 50% pain relief
- Intolerable side effects

Limit of two intraspinal drug trials for preliminary consideration of chronic intractable pain or spasticity management with permanent implantable device in non-terminal individuals.

NOTE: Intrathecal trials are not indicated in opioid-naïve individuals

Contraindications for Intraspinal Drug Trial

- Active systemic or spinal infection
- Body habitus that is insufficient to support the weight and bulk of the device

EXCLUSIONS

These requests are excluded from consideration under this guideline:

- Implantation of intrathecal catheters or ports for chemotherapy
- Post-operative pain control
- Caudal or spinal anesthesia for surgery

CODING AND STANDARDS

Codes

CPT	
Code	**Description**
Cervical/Thoracic Interlaminar Epidural	
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

CPT	
Code	**Description**
	substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)
Cervical/Thoracic Transforaminal Epidural	
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)
Lumbar/Sacral Interlaminar Epidural	
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)
Lumbar/Sacral Transforaminal Epidural	
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)

Applicable Lines of Business

☒	CHIP (Children's Health Insurance Program)
☒	Commercial
☒	Exchange/Marketplace
☒	Medicaid
☒	Medicare Advantage

BACKGROUND

Medical Necessity

Medical necessity management for epidural injections includes an initial evaluation including history and physical examination as well as a psychosocial and functional assessment. The following must be determined:

- Nature of the suspected organic problem
- Non-responsiveness to active **conservative treatment***
- Level of pain and functional disability
- Conditions which may be contraindications to epidural injections
- Responsiveness to prior interventions

NOTE: It is generally considered **not medically necessary** to perform multiple interventional pain procedures on the same date of service. Documentation of a medical reason to perform injections in different regions on the same day can be provided and will be considered on a case-by-case basis (e.g., holding anticoagulation therapy on two separate dates creates undue risk for the patient). Different types of injections in the same spinal region (cervical, thoracic, or lumbar) should not be done on the same day with the exception of a facet injection and ESI (Epidural Spine Injection) performed during the same session for a synovial cyst confirmed on imaging.

Conservative Treatment*

Non-operative conservative treatment should include a multimodality approach consisting of at least one active and one inactive component targeting the affected spinal region.

- Active Modalities
  - Physical therapy
  - Physician-supervised home exercise program (HEP)**

- Chiropractic care
- Inactive Modalities
- Medications (e.g., NSAIDs, steroids, analgesics)
  - Injections (e.g., epidural steroid injection, selective nerve root block)
  - Medical devices (e.g., TENS unit, bracing)

Home Exercise Program (HEP)**

The following two elements are required to meet conservative therapy guidelines for HEP:

- Documentation of an exercise prescription/plan provided by a physician, physical therapist, or chiropractor **AND**
- Follow-up documentation regarding completion of HEP after the required 6-week timeframe or inability to complete HEP due to a documented medical reason (i.e., increased pain or inability to physically perform exercises).

ANALYSIS OF EVIDENCE

Epidural Interventions in the Management of Chronic Spinal Pain: American Society of Interventional Pain Physicians (ASIPP) Comprehensive Evidence-Based Guidelines [(1)]:

- **Study Design**: This document is a comprehensive review and guideline update by the American Society of Interventional Pain Physicians (ASIPP) on epidural interventions for managing chronic spinal pain. It includes a systematic review of the literature, best evidence synthesis, and recommendations based on the evidence.
- **Target Population**: Patients with chronic spinal pain, including those with disc herniation, spinal stenosis, axial discogenic pain, and post-surgery syndrome.
- **Key Factors**: The guidelines are based on a review of 47 systematic reviews and 43 randomized controlled trials (RCTs). The evidence is categorized by the type of epidural intervention (caudal, interlaminar, transforaminal) and the specific spinal condition. The guidelines provide recommendations for the effectiveness of these interventions, with evidence levels ranging from Level I (strong) to Level IV (limited) depending on the condition and type of intervention.

An Update of Comprehensive Evidence-Based Guidelines for Interventional Techniques in Chronic Spinal Pain. Part II: Guidance and Recommendations [(3)]:

- **Study Design**: This document is an update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain by ASIPP. It includes systematic reviews, evidence synthesis, and recommendations for various interventional techniques.
- **Target Population**: Patients with chronic spinal pain, including those with lumbar, cervical, and thoracic spine conditions.

- **Key Factors**: The guidelines cover diagnostic and therapeutic interventions, including epidural injections, facet joint interventions, sacroiliac joint injections, and percutaneous adhesiolysis. The evidence is categorized by the type of intervention and spinal condition, with recommendations based on the strength of the evidence. The guidelines emphasize the importance of evidence-based practice and the need for high-quality studies to support clinical decision-making.

The American Society of Pain and Neuroscience (ASPN) Evidence-Based Clinical Guideline of Interventional Treatments for Low Back Pain [5]:

- **Study Design**: This document is an evidence-based clinical guideline by the American Society of Pain and Neuroscience (ASPN) for interventional treatments of low back pain. It includes a comprehensive review of the literature, evidence synthesis, and recommendations for various interventional treatments.
- **Target Population**: Patients with low back pain, including those with lumbar radiculopathy, spinal stenosis, and discogenic pain.
- **Key Factors**: The guidelines cover a wide range of interventional treatments, including epidural steroid injections, facet interventions, trigger point injections, and intradiscal regenerative therapies. The evidence is graded using the United States Preventive Services Task Force (USPSTF) criteria, with recommendations based on the strength of the evidence. The guidelines aim to provide clinicians with the most comprehensive and up-to-date information on the effectiveness and safety of interventional treatments for low back pain.

SUMMARY OF EVIDENCE

Shared Findings [1,3,5]:

- All three articles agree on the effectiveness of ESIs in managing chronic spinal pain, with varying levels of evidence supporting their use.
- The articles emphasize the importance of using high-quality, evidence-based guidelines to inform clinical practice.

Differing Findings:

- Manchikanti et al 2021 focuses on therapeutic epidural procedures and provides detailed guidelines for their use but does not address single injection trials for intrathecal pumps. [1]
- Manchikanti et al 2013 includes guidelines for various interventional techniques, including implantable devices like intrathecal pumps, but finds limited evidence for single injection trials. [3]
- Sayed et al 2022 provides a broader review of interventional treatments, including ESIs, but does not focus on single injection trials for intrathecal pumps. [5]

In summary, while all three articles support the use of ESIs for chronic spinal pain, they vary in their focus and the level of detail provided for single injection trials for intrathecal pumps.

Manchikanti et al 2013 is the only one that addresses intrathecal pumps, albeit with limited evidence.

POLICY HISTORY

Date	Summary
December 2025	• Updated Disclaimer, General Information, and Legislative Language • Added CPT code table to reflect new formatting. • Removed Washington State regulatory language. • Added Summary of Evidence and Analysis of Evidence
December 2024	• This guideline replaces Evolent Clinical Guideline 408 Epidural Spine Injections and Single Injection Trials For Intrathecal Pumps
January 2024	• Added conservative tx language • Added legislative language for WA state • Added criteria for additional intrathecal trials

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Specialty Services Clinical Guideline Review Committee

Disclaimer

Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. Evolent clinical guidelines contain guidance that requires prior authorization and service limitations. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and

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Evolent Clinical Guideline 1753 for Paravertebral Facet Joint Injections or Blocks

Guideline Number: Evolent_CG_1753	**Applicable Codes**	
"Evolent" refers to Evolent Health LLC and Evolent Specialty Services, Inc. 		
Original Date: October 2012	**Last Revised Date:** December 2025	**Implementation Date:** July 2026

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STATEMENT

General Information

- *It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *The guideline criteria in the following sections were developed utilizing evidence-based and peer-reviewed resources from medical publications and societal organization guidelines as well as from widely accepted standard of care, best practice recommendations.*

Special Note

- Any injection performed at least two years from prior injections in the same region will be considered a new episode of care and the **INITIAL** injection requirements must be met for approval. Events such as surgery on the same spinal region or any new pathology would also prompt a new episode of care.
- Unilateral injections performed at the same level on the right vs. left within 1 month of each other would be considered as one procedure toward the total number of facet procedures allowed per 12 months.

INDICATIONS FOR FACET JOINT INJECTIONS OR MEDIAL BRANCH NERVE BLOCKS

Facet Joint Pain [1]

To confirm non-radicular pain suggestive of facet joint or pars interarticularis origin, **ALL** the following must be met:

- Pain that:
  - Is causing functional disability or average pain level of ≥ 6 (scale of 0 to 10) related to the requested spinal region
  - Duration for at least **3 months**
  - Is either:
    - By history, mainly axial or non-radicular
    - Is radicular due to stenosis caused by synovial cyst (confirmed on imaging)[2]
  - Is of primary source that is not sacroiliac joint pain, discogenic pain, disc herniation, or radiculitis
- If diagnosed chronic lumbar spondylolysis

- Imaging studies confirming the presence of a pars interarticularis fracture/defect are required.

- Failure to respond to non-operative **conservative treatment*** targeting the requested spinal region for a minimum of six (6) weeks in the last six (6) months unless the medical reason this treatment cannot be done is clearly documented
  - Failure of conservative treatment is defined as one of the following:
    - Lack of meaningful improvement after a full course of treatment; **OR**
    - Progression or worsening of symptoms during treatment; **OR**
    - Documentation of a medical reason the member is unable to participate in the treatment (*Closure of medical or therapy offices, patient inconvenience, or noncompliance without explanation does not constitute 'inability to complete' treatment*)
  - **OR** details of engagement in ongoing non-operative **conservative treatment*** if the individual has had prior spinal injections in the same region

Imaging Guidance [3–5]

- ALL procedures must be performed under imaging guidance.
  - The facet joint is commonly identified under image guidance by Computed tomography (CT) or Fluoroscopy. Medial Branch Blocks are commonly identified by Fluoroscopy. Ultrasound guidance can be an effective alternative if CT or fluoroscopy guided techniques are contraindicated; however, individual patient factors such as poor visualization due to deeper tissue layers e.g., increased Body Mass Index (BMI) may contribute to substandard image resolution.

Repeat Injections [1,6]

Facet joint injections and medial branch nerve blocks may be repeated only as **medically necessary**. Injections performed on different days of service require separate authorization, and the following criteria must be met for repeat injections:

Initial Treatment Phase

- Up to 2 diagnostic injections may be performed in the initial diagnostic phase, no sooner than 2 weeks apart:
  - At the same level, provided at least 50% pain relief or significant documented functional improvement is obtained OR
  - a second diagnostic injection may be performed at a different spinal level or with a change in technique (e.g., from an intra-articular facet injection to a medial branch nerve block) if:
    - there is a question about the pain generator or evidence of multi-level pathology AND
    - the first diagnostic injection was unsuccessful at achieving any pain relief.

- If the most recent injection was a diagnostic block with local anesthetic only, there must be at least 7 days between injections.

Therapeutic Phase

- Facet joint injections may only be repeated after the initial diagnostic phase if:
  - It is an initial therapeutic injection subsequent to a successful initial treatment phase that provided at least 50% relief or functional improvement.
  - the individual has had at least 50% pain relief or significant documented functional improvement for a **minimum of 2 months** before each repeat therapeutic injection.
  - The individual continues to have pain causing functional disability or average pain level ≥ 6 on a scale of 0 to 10 related to the requested spinal region.
  - The individual is engaged in ongoing active **conservative treatment*** unless the medical reason this treatment cannot be done is clearly documented [7]
    - Diagnostic injections within 1 month of the previous injection do not require documentation of ongoing active conservative therapy.
- In the diagnostic phase, a maximum of 2 procedures may be performed. Repeat diagnostic injections after prior radiofrequency neurolysis are approvable if there is a question about the pain generator, different levels are to be targeted, or if there is surgery in the same spinal region.
- A maximum of 4 facet injections may be performed in a 12-month period per **spinal region** (except under unusual circumstances, such as a recurrent injury)
- If different spinal regions are being treated, injections should be administered at intervals of no sooner than 7 days unless a medical reason is provided to necessitate injecting multiple regions on the same date of service (see **Medical Necessity**)

NOTE: Radiofrequency ablation (RFA) procedures should be considered in individuals with a successful **medial branch nerve block** (at least 70% pain relief or improved ability to function), but with insufficient sustained relief (less than 2-3 months improvement). RFA cannot be performed on patients who have received an intra-articular joint injection instead of diagnostic medial branch blocks.

EXCLUSIONS

These requests are excluded from consideration:

- Sacral lateral branch blocks (S1, S2, S3)
- Atlantoaxial joint injections (C1-2)
- Occipital nerve blocks
- Hardware injection or block for diagnosis or treatment of post-surgical or other spine pain

CONTRAINDICATIONS [3]

Although there are no absolute contraindications there are relative contraindications that include:

- Active systemic or spinal infection
- Skin infection at the site of needle puncture
- Inability to obtain percutaneous access to the target facet joint.
- Medication or contrast agent allergy

CODING AND STANDARDS

Codes

CPT	
Code	**Description**
Cervical Thoracic Region	
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
+64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) 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 levels (List separately in addition to code for primary procedure)
0213T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; single level
+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)

CPT	
Code	**Description**
+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
Lumbar Region	
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)
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)

Applicable Lines of Business

☒	CHIP (Children's Health Insurance Program)
☒	Commercial
☒	Exchange/Marketplace
☒	Medicaid
☒	Medicare Advantage

BACKGROUND

Definitions [3]

Facet joints may refer pain to adjacent structures, making the underlying diagnosis difficult as referred pain may assume a pseudoradicular pattern. Lumbar facet joints may refer pain to the back, buttocks, and lower extremities while cervical facet joints may refer pain to the head, neck, and shoulders.

Imaging studies may detect changes in facet joint architecture, but correlation between radiologic findings and symptoms is unreliable. Although clinical signs are unsuitable for diagnosing facet joint-mediated pain, they may be of value in selecting individuals for controlled local anesthetic blocks of either the medial branches or the facet joint itself.

Facet joint interventions include intraarticular injections and medial branch nerve blocks in the lumbar, cervical, and thoracic spine. Prior to performing this procedure, shared decision-making between patient and physician must occur, and the patient must understand the procedure and its potential risks and results. Facet joint injections or medial branch nerve blocks require guidance imaging.

Medical Necessity

Medical necessity management for paravertebral facet interventions include an initial evaluation including history and physical examination and a psychosocial and functional assessment. The following must also be determined [1]:

- Nature of the suspected organic problem
- Non-responsiveness to **conservative treatment***
- Level of pain and functional disability
- Conditions which may be contraindications to paravertebral facet injections
- Responsiveness to prior interventions

It is generally considered not medically necessary to perform multiple interventional pain procedures on the same date of service. Documentation of a medical reason to perform

injections in different regions on the same day can be provided and will be considered on a case-by-case basis (e.g., holding anticoagulation therapy on two separate dates creates undue risk for the patient). Different types of injections in the same spinal region (cervical, thoracic, or lumbar) should not be done on the same day with the exception of a facet injection and ESI performed during the same session for a synovial cyst confirmed on imaging.

Conservative Treatment* (6)

Non-operative treatment should include a multimodality approach consisting of at least one (1) active and one (1) inactive component targeting the affected spinal region.

- Active components
  - Physical Therapy
  - Physician-supervised **home exercise program****
  - Chiropractic Care
- Inactive Modalities
  - Medications (e.g., NSAIDs, steroids, analgesics)
  - Injections (e.g., epidural steroid injection, selective nerve root block)
  - Medical Devices (e.g., TENS unit, bracing)

Home Exercise Program (HEP)** (8)

The following two elements are required to meet conservative therapy guidelines for HEP:

- Documentation of an exercise prescription/plan provided by a physician, physical therapist, or chiropractor **AND**
- Follow-up documentation regarding completion of HEP after the required 6-week timeframe or inability to complete HEP due to a documented medical reason (e.g., increased pain or inability to physically perform exercises).

SUMMARY OF EVIDENCE

Consensus Practice Guidelines on Interventions for Lumbar Facet Joint Pain [(6)]

Study Design:

- Multispecialty, international working group developed consensus guidelines.
- Modified Delphi method for consensus; literature review included MEDLINE, Embase, Google Scholar, Cochrane.
- Evidence graded using US Preventive Services Task Force criteria (Grades A–D, I statement; certainty: High, Moderate, Low).

Target Population:

- Adults with suspected lumbar facetogenic pain, especially those considered for lumbar facet blocks or radiofrequency ablation (RFA).

Key Factors:

- **Prevalence:** Wide range (4.8%–>50%) due to diagnostic variability.
- **Guideline Scope:** Addressed 17 clinical questions (diagnosis, imaging, conservative care, procedural technique, complications).
- **Findings:**
  - No pathognomonic clinical signs; physical exam and history have low sensitivity but some specificity (e.g., Revel's criteria).
  - Imaging (SPECT) has moderate evidence for identifying painful joints before medial branch blocks (MBB); MRI/CT less useful.
  - Conservative care (PT, medications) recommended for ≥3 months before interventions.
  - Fluoroscopy is gold standard for guidance; ultrasound feasible in select cases.
  - MBB preferred over intra-articular (IA) injections for RFA selection; IA injections reserved for specific populations.
  - Sedation increases false-positive rates; avoid routine use.
  - Optimal injectate volumes: <0.5 mL for MBB, <1.5 mL for IA.
  - Cutoff for positive block: ≥50% pain relief.
  - Recommendations are pragmatic, balancing clinical and research needs.

ASIPP Guidelines for Facet Joint Interventions [1]

Study Design:

- Comprehensive evidence-based guideline by the American Society of Interventional Pain Physicians (ASIPP).
- Literature review and best evidence synthesis; grading system from Level I (strong) to Level V (consensus).

Target Population:

- Patients with chronic axial spinal pain (low back, neck, thoracic), including those with failed conservative management.

Key Factors:

- **Diagnosis:**
  - Physical exam and clinical assessment: Level II evidence for patient selection after ≥3 months of failed conservative care.
  - Imaging: Fluoroscopic or CT guidance mandatory (Level I); SPECT, MRI, CT less reliable.

- Diagnostic blocks (MBB): Level I–II evidence for lumbar/cervical/thoracic spine; prevalence of facet pain 27–40% (lumbar), 29–60% (cervical), 34–48% (thoracic); false-positive rates 27–47%.

- **Therapeutic Interventions:**
  - Lumbar RFA: Level II evidence, moderate recommendation (11 RCTs).
  - Facet nerve blocks: Level II evidence, moderate recommendation.
  - IA injections: Level IV evidence, weak recommendation (mostly ineffective without anesthetic).
- **Additional Recommendations:**
  - Antithrombotic therapy: May continue for moderate/low-risk procedures.
  - Sedation: Avoid opioids during diagnostic procedures; moderate sedation for therapeutic interventions.
- **Trends:**
  - Facet interventions increased 18.8% (2009–2018); costs rose 79%.
  - Opioid prescriptions and overdose deaths discussed in context of pain management.

ASPN Evidence-Based Clinical Guideline for Interventional Treatments of Low Back Pain [3]

Study Design:

- Multidisciplinary guideline committee (anesthesiology, neurosurgery, physiatry, radiology, pain psychology, ethics).
- Literature search (2000–present) across major databases; evidence graded using modified USPSTF criteria (RCT > prospective observational > case series > expert opinion).

Target Population:

- Adults with low back pain (LBP), including lumbar radiculopathy, myofascial pain syndrome, facet joint pain, sacroiliac joint pain, discogenic pain, spinal stenosis, vertebral compression fractures.

Key Factors:

- **Injection Therapy:**
  - Epidural steroid injections: Level I evidence for disc herniation; Level II for stenosis/axial pain; Grade A, high certainty.
  - Trigger point injections: >40 RCTs; medication type does not affect outcomes; eliciting twitch response best; Grade A.
  - Facet interventions: IA injections not therapeutic; MBB prognostic for RFA; image guidance preferred; Grade A for MBB as prognostic, Grade C for IA steroid injections.

- Sacroiliac joint injections: Diagnostic blocks gold standard; dual blocks with ≥70% pain relief most accurate; Grade A for diagnosis, Grade B for short-term relief.

- **Other Interventions:**
  - Intradiscal regenerative therapies (PRP, MSCs): Emerging evidence, mostly small studies.
  - Percutaneous image-guided lumbar decompression: RCTs and prospective studies support efficacy and safety.
  - Vertebral augmentation: Multiple RCTs show pain and functional improvement; Grade A.
  - Neuromodulation (SCS, PNFS): Strong evidence for post-surgical pain; moderate for non-surgical LBP.
  - Radiofrequency ablation: Multiple RCTs and observational studies support efficacy for facet-mediated pain.

ANALYSIS OF EVIDENCE

Comparison of relevant research demonstrates a broad consensus on the following points:

- **Efficacy for Chronic Low Back Pain**
  - **Limited Therapeutic Value:** All three guidelines agree that intra-articular (IA) facet joint injections have limited or no long-term therapeutic benefit for chronic low back pain (LBP). They are not recommended as a stand-alone treatment for facet-mediated pain, nor do they replace or delay the need for radiofrequency ablation (RFA). [3]
  - **Prognostic Use:** IA injections may have a role as a prognostic tool before RFA, but medial branch blocks (MBB) are generally preferred for this purpose. [6]
- **Imaging Guidance**
  - **Fluoroscopy as Gold Standard:** All guidelines emphasize that facet joint injections should be performed under fluoroscopic or CT guidance for accuracy and safety. Ultrasound may be considered in select cases but is not universally accepted as a replacement for fluoroscopy. [6]
- **Patient Selection and Diagnostic Value**
  - **Diagnostic Uncertainty:** There is consensus that clinical history and physical examination alone are insufficient to reliably diagnose facetogenic pain. Diagnostic blocks (MBB or IA) are necessary, but even these have notable false-positive rates. [6]
- **Combination Therapy**
  - **Adjunctive Role:** There is some evidence that combining IA facet injections with oral NSAIDs or other conservative therapies may be more effective than injection therapy alone, particularly in acute or inflammatory cases. [3]

In summary, paravertebral facet joint injections, especially intra-articular, are not recommended as a stand-alone long-term therapy for chronic LBP. Their main value is as a diagnostic or prognostic tool, with MBB being preferred over IA injections. Fluoroscopic or CT guidance is essential for accuracy and safety. IA injections may have a role in acute or inflammatory cases, or as part of a multimodal approach, but should not be the only intervention. The highest quality evidence and strongest recommendations are for MBB and RFA, not for IA injections. [1,3,6]

POLICY HISTORY

Date	Summary
December 2025	• Added second bullet to Statement • Reordered indications for clarity • Removed legislative language to external regulatory document • Added Summary of Evidence and Analysis of Evidence per Medicare requirements.
December 2024	• This guideline replaces Evolent Clinical Guideline 301 for Paravertebral Facet Joint Injections or Blocks • Added the correct consensus language for conservative care from pilot study in Facet Joint Pain section • Moved "Unilateral injections performed at the same level on the right vs. left within 1 month of each other would be considered as one procedure toward the total number of facet procedures allowed per 12 months" from Repeat Injections section to Special Note section • Clarified between initial and therapeutic treatment phase in Repeat Injections section • Corrected "see Note" to "see Medical Necessity" • Added "medication or contrast agent allergy" to Contraindication section • Hyperlinked "conservative treatment" and "medical necessity" • Included the full WA bill

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Specialty Services Clinical Guideline Review Committee

Disclaimer

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Evolent Clinical Guideline 1754 for Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis)

Guideline Number: Evolent_CG_1754	**Applicable Codes**	
"Evolent" refers to Evolent Health LLC and Evolent Specialty Services, Inc. ***© 2012 - 2026 Evolent. All rights Reserved.***		
Original Date: October 2012	**Last Revised Date:** December 2025	**Implementation Date:** July 2026

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STATEMENT

General Information

- *It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *The guideline criteria in the following sections were developed utilizing evidence-based and peer-reviewed resources from medical publications and societal organization guidelines as well as from widely accepted standard of care, best practice recommendations.*

Special Note

Unilateral procedures performed at the same level(s) on the right vs left:

- If performed within 1 month of each other are counted as one procedure
- A minimum timeframe is not required between denervation procedures
- Opposite side denervation procedures performed within 1 month of the first side do not require follow-up information to be submitted.

INDICATIONS FOR PARAVERTEBRAL FACET JOINT DENERVATION

(RADIOFREQUENCY NEUROLYSIS)

Facet Joint Pain [1–4]

For the treatment of facet-mediated pain, **ALL** of the following must be met:

- Pain that:
  - Is causing functional disability or average pain level of ≥ 6 on a scale of 0 to 10 related to the requested spinal region
  - Is of at least **3 months** duration
    - For radiofrequency ablation following diagnostic medial branch blocks, a positive response to at least one local anesthetic block of the facet joint nerves (medial branch blocks) with at least 70% pain relief or improved ability to function for a minimal duration at least equal to that of the local anesthetic, but with insufficient sustained relief (less than 3 months duration) documented as:
    - Continued pain, after the diagnostic relief period, causing functional disability or average pain level of ≥ 6 on a scale of 0 to 10 related to the requested spinal region

- Is not primarily sacroiliac joint pain, discogenic pain, disc herniation, or radiculitis

- Failure of **conservative treatment*** for a minimum of six (6) weeks in the last six (6) months
  - Failure of conservative treatment is defined as one of the following:
    - Lack of meaningful improvement after a full course of treatment; **OR**
    - Progression or worsening of symptoms during treatment; **OR**
    - Documentation of a medical reason the member is unable to participate in the treatment (*Closure of medical or therapy offices, patient inconvenience, or noncompliance without explanation does not constitute 'inability to complete' treatment*)

Imaging Guidance [3,5]

- All procedures must be performed using fluoroscopic or CT guidance
  - The facet joint is commonly identified under image guidance by Computed tomography (CT) or Fluoroscopy. Medial Branch Blocks are commonly identified by Fluoroscopy.

Repeat Procedures [2,3,5]

Facet joint denervation procedures may be repeated only as **medically necessary**. Procedures performed on different days of service require separate authorization, and the following criteria must be met for repeat procedures:

- Positive response to prior radiofrequency denervation procedures with at least 50% pain relief or improved ability to function for at least 4 months
- The individual continues to have pain causing functional disability or average pain level ≥ 6 on a scale of 0-10 related to the requested spinal region.
- The individual is engaged in ongoing non-operative **conservative treatment*** unless the medical reason this treatment cannot be done is clearly documented.
- A maximum of 2 facet denervation procedures may be performed in a 12-month period **per spinal region.**

EXCLUSIONS

These requests are excluded from consideration under this guideline:

- Radiofrequency denervation of the sacroiliac joint and/or sacral lateral branches (S1, S2, S3)

CONTRAINDICATIONS [1]

- Active systemic or spinal infection
- Skin infection at the site of needle puncture

CODING AND STANDARDS

Codes

CPT	
Code	**Description**
Cervical Thoracic Region	
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)
Lumbar Region	
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
+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)

Applicable Lines of Business

☒	CHIP (Children's Health Insurance Program)
☒	Commercial
☒	Exchange/Marketplace
☒	Medicaid
☒	Medicare Advantage

BACKGROUND

Definitions

Facet joints may refer pain to adjacent structures, making the underlying diagnosis difficult as referred pain may assume a pseudoradicular pattern. Lumbar facet joints may refer pain to the back, buttocks, and lower extremities while cervical facet joints may refer pain to the head, neck, and shoulders.

Imaging studies may detect changes in facet joint architecture, but correlation between radiologic findings and symptoms is unreliable. Although clinical signs are unsuitable for diagnosing facet joint-mediated pain, they may be of value in selecting individuals for controlled local anesthetic blocks of either the medial branches or the facet joint itself.

Interventions used in the treatment of individuals with a confirmed diagnosis of facet joint pain include medial branch nerve blocks in the lumbar, cervical, and thoracic spine; and radiofrequency neurolysis. The medial branch of the primary dorsal rami of the spinal nerves has been shown to be the primary innervations of facet joints.

Therapeutic Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis)

Local anesthetic block is followed by the passage of radiofrequency current to generate heat and coagulate the target medial branch nerve. Traditional radiofrequency and cooled radiofrequency are included by this definition. Pulsed radiofrequency, cryo-ablation, or laser ablation are not included in this definition.

Radiofrequency neurolysis is a minimally invasive treatment for cervical, thoracic, and lumbar facet joint pain. It involves using energy in the radiofrequency range to cause necrosis of specific nerves (medial branches of the dorsal rami), preventing the neural transmission of pain. The objective of radiofrequency neurolysis is to both provide relief of pain and reduce the likelihood of recurrence.

Members of the American Society of Anesthesiologists (ASA) and the American Society of Regional Anesthesia and Pain Medicine (ASRA) have agreed that conventional or thermal radiofrequency ablation of the medial branch nerves to the facet joint should be performed for

neck or low back pain. Radiofrequency neurolysis has been employed for over 30 years to treat facet joint pain. Prior to performing this procedure, shared decision-making between patient and physician must occur, and the patient must understand the procedure and its potential risks and results.

Medical Necessity

Medical necessity management for paravertebral facet interventions includes an initial evaluation including history and physical examination and a psychosocial and functional assessment. The following must also be determined [2]:

- Nature of the suspected organic problem
- Non-responsiveness to **conservative treatment***
- Level of pain and functional disability
- Conditions which may be contraindications to paravertebral facet injections
- Responsiveness to prior interventions

It is generally considered **not medically necessary** to perform multiple interventional pain procedures on the same date of service. Documentation of a medical reason to perform injections in different regions on the same day can be provided and will be considered on a case-by-case basis (e.g., holding anticoagulation therapy on two separate dates creates undue risk for the patient).

Conservative Treatment* [1,3]

Non-operative treatment should include a multimodality approach consisting of at least one (1) active and one (1) inactive component targeting the affected spinal region.

- Active components
  - Physical therapy
  - Physician-supervised **home exercise program****
  - Chiropractic care
- Inactive Modalities
  - Medications (e.g., NSAIDs, steroids, analgesics)
  - Injections (e.g., epidural steroid injection, selective nerve root block)
  - Medical Devices (e.g., TENS unit, bracing)

Home Exercise Program (HEP)** [6]

The following two elements are required to meet conservative therapy guidelines for HEP:

- Documentation of an exercise prescription/plan provided by a physician, physical therapist, or chiropractor **AND**
- Follow-up documentation regarding completion of HEP after the required 6-week

timeframe or inability to complete HEP due to a documented medical reason (e.g., increased pain or inability to physically perform exercises).

SUMMARY OF EVIDENCE

Consensus Practice Guidelines on Interventions for Lumbar Facet Joint Pain [3]

Study Design:

- Multispecialty, international working group developed consensus guidelines.
- Modified Delphi method for consensus; literature review included MEDLINE, Embase, Google Scholar, Cochrane.
- Evidence graded using US Preventive Services Task Force criteria (Grades A–D, I statement; certainty: High, Moderate, Low).

Target Population:

- Adults with suspected lumbar facetogenic pain, especially those considered for lumbar facet blocks or radiofrequency ablation (RFA).

Key Factors:

- **Prevalence:** Wide range (4.8%–>50%) due to diagnostic variability.
- **Guideline Scope:** Addressed 17 clinical questions (diagnosis, imaging, conservative care, procedural technique, complications).
- **Findings:**
  - No pathognomonic clinical signs; physical exam and history have low sensitivity but some specificity (e.g., Revel's criteria).
  - Imaging (SPECT) has moderate evidence for identifying painful joints before medial branch blocks (MBB); MRI/CT less useful.
  - Conservative care (PT, medications) recommended for ≥3 months before interventions.
  - Fluoroscopy is gold standard for guidance; ultrasound feasible in select cases.
  - MBB preferred over intra-articular (IA) injections for RFA selection; IA injections reserved for specific populations.
  - Sedation increases false-positive rates; avoid routine use.
  - Optimal injectate volumes: <0.5 mL for MBB, <1.5 mL for IA.
  - Cutoff for positive block: ≥50% pain relief.
  - Recommendations are pragmatic, balancing clinical and research needs.

ASIPP Guidelines for Facet Joint Interventions [2]

Study Design:

- Comprehensive evidence-based guideline by the American Society of Interventional Pain Physicians (ASIPP).
- Literature review and best evidence synthesis; grading system from Level I (strong) to Level V (consensus).

Target Population:

- Patients with chronic axial spinal pain (low back, neck, thoracic), including those with failed conservative management.

Key Factors:

- **Diagnosis:**
  - Physical exam and clinical assessment: Level II evidence for patient selection after ≥3 months of failed conservative care.
  - Imaging: Fluoroscopic or CT guidance mandatory (Level I); SPECT, MRI, CT less reliable.
  - Diagnostic blocks (MBB): Level I–II evidence for lumbar/cervical/thoracic spine; prevalence of facet pain 27–40% (lumbar), 29–60% (cervical), 34–48% (thoracic); false-positive rates 27–47%.
- **Therapeutic Interventions:**
  - Lumbar RFA: Level II evidence, moderate recommendation (11 RCTs).
  - Facet nerve blocks: Level II evidence, moderate recommendation.
  - IA injections: Level IV evidence, weak recommendation (mostly ineffective without anesthetic).
- **Additional Recommendations:**
  - Antithrombotic therapy: May continue for moderate/low-risk procedures.
  - Sedation: Avoid opioids during diagnostic procedures; moderate sedation for therapeutic interventions.
- **Trends:**
  - Facet interventions increased 18.8% (2009–2018); costs rose 79%.
  - Opioid prescriptions and overdose deaths discussed in context of pain management.

ASPN Evidence-Based Clinical Guideline for Interventional Treatments of Low Back Pain [1]

Study Design:

- Multidisciplinary guideline committee (anesthesiology, neurosurgery, physiatry, radiology, pain psychology, ethics).

- Literature search (2000–present) across major databases; evidence graded using modified USPSTF criteria (RCT > prospective observational > case series > expert opinion).

Target Population:

- Adults with low back pain (LBP), including lumbar radiculopathy, myofascial pain syndrome, facet joint pain, sacroiliac joint pain, discogenic pain, spinal stenosis, vertebral compression fractures.

Key Factors:

- **Injection Therapy:**
  - Epidural steroid injections: Level I evidence for disc herniation; Level II for stenosis/axial pain; Grade A, high certainty.
  - Trigger point injections: >40 RCTs; medication type does not affect outcomes; eliciting twitch response best; Grade A.
  - Facet interventions: IA injections not therapeutic; MBB prognostic for RFA; image guidance preferred; Grade A for MBB as prognostic, Grade C for IA steroid injections.
  - Sacroiliac joint injections: Diagnostic blocks gold standard; dual blocks with ≥70% pain relief most accurate; Grade A for diagnosis, Grade B for short-term relief.
- **Other Interventions:**
  - Intradiscal regenerative therapies (PRP, MSCs): Emerging evidence, mostly small studies.
  - Percutaneous image-guided lumbar decompression: RCTs and prospective studies support efficacy and safety.
  - Vertebral augmentation: Multiple RCTs show pain and functional improvement; Grade A.
  - Neuromodulation (SCS, PNFS): Strong evidence for post-surgical pain; moderate for non-surgical LBP.
  - Radiofrequency ablation: Multiple RCTs and observational studies support efficacy for facet-mediated pain.

ANALYSIS OF EVIDENCE

Comparison of the research findings demonstrate several key points of agreement:

- **Efficacy and Recommendation** [1–3]
  - **All three guidelines support the use of conventional RFA for lumbar facet joint pain** in well-selected patients, with moderate to high certainty of benefit.
  - **RFA is superior to placebo/sham procedures** for pain relief and functional improvement in the short and intermediate term, and often in the long term as well.

- **Medial branch blocks (MBB) are the preferred prognostic tool** before RFA; intra-articular injections are less predictive.

- **Patient Selection and Technique** [3]
  - **Stringent patient selection improves outcomes** but may increase false negatives. Most guidelines recommend using MBB with ≥50% pain relief as the cutoff for proceeding to RFA.
  - **Electrode placement parallel to the nerve** is recommended for optimal lesioning and clinical success.
  - **Repeat RFA is effective** for patients who experience return of pain after initial benefit; repeat prognostic blocks are not always necessary unless pain characteristics change.
- **Safety and Complications** [1,3]
  - **RFA is generally safe**, with most complications being minor and self-limiting (e.g., transient neuritis, localized numbness, rare neuropathic pain).
  - **Serious complications are rare** but can include nerve root injury, muscle denervation, and, in rare cases, spinal cord injury.
- **Evidence Quality** [1,2]
  - **Multiple randomized controlled trials (RCTs) and systematic reviews** support the efficacy of RFA for lumbar facet joint pain, with moderate to high quality evidence.

In summary, conventional RFA is effective and recommended for lumbar facet joint pain in well-selected patients, with moderate to high certainty of benefit. Medial branch blocks (MBB) are the preferred prognostic tool; intra-articular injections are less predictive and not recommended as sole therapy. Technique matters: parallel electrode placement and imaging guidance are critical for success. Repeat RFA is effective for recurrent pain; repeat blocks are not always necessary. Safety profile is favorable, with most complications being minor and self-limiting. Evidence is robust, with multiple RCTs and systematic reviews supporting efficacy. [1–3]

POLICY HISTORY

Date	Summary
December 2025	• Added second bullet to General Information • Removed legislative language to separate regulatory document • Added Summary of Evidence and Analysis of Evidence per Medicare requirements
December 2024	• This guideline replaces Evolent Clinical Guideline 302 for Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis)

Date	Summary
	● Hyperlinked "conservative treatment" and "medical necessity" ● Added Medical Necessity section for consistency with Paravertebral Facet Joint Injections or Blocks guideline

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Specialty Services Clinical Guideline Review Committee

Disclaimer

Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. Evolent clinical guidelines contain guidance that requires prior authorization and service limitations. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.

Evolent Clinical Guidelines are comprehensive and inclusive of various procedural applications for each service type. Our guidelines may be used to supplement Medicare criteria when such criteria is not fully established. When Medicare criteria is determined to not be fully established, we only reference the relevant portion of the corresponding Evolent Clinical Guideline that is applicable to the specific service or item requested in order to determine medical necessity.

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Evolent Clinical Guideline 1756 for Sacroiliac Joint Injections

Guideline Number: Evolent_CG_1756	**Applicable Codes**	
"Evolent" refers to Evolent Health LLC and Evolent Specialty Services, Inc. 		
Original Date: January 2014	**Last Revised Date:** December 2024	**Implementation Date:** July 2025

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STATEMENT

General Information

It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.

Special Note

Any injection performed at least two years from prior injections in the same region will be considered a new episode of care and the **INITIAL** injection requirements must be met for approval. Events such as surgery on the same spinal region or any new pathology would also prompt a new episode of care.

See Legislative Language for specific mandates in Washington

INDICATIONS FOR SACROILIAC JOINT INJECTIONS (INTRAARTICULAR OR LIGAMENTOUS INJECTIONS ONLY)

Sacroiliac Joint Pain [1,2,3,4]

For the treatment of sacroiliac joint (SIJ) pain **ALL** of the following must be met:

- Primarily axial low back pain (below level of L5) which may radiate to the groin or lower extremity
- Pain causing functional disability or average pain level of ≥ 6 on a scale of 0 to 10 related to the requested spinal region
- A cluster of any three (3) of the following positive provocation exam findings to suggest the diagnosis [5,6,7]:
  - Pelvic (SI) distraction test
  - Pelvic (SI) compression test
  - Sacral Thrust test
  - FABER (Patrick's test)
  - Posterior shear test
  - Yeoman's test
  - Gaenslen's test
  - Thigh Thrust test
- Duration of pain of at least **3 months**
- Failure to respond to non-operative conservative treatment targeting the requested spinal region for a minimum of 6 weeks in the last 6 months unless the medical reason this treatment cannot be done is clearly documented;

- **OR** details of active engagement in ongoing non-operative conservative treatment if the individual has had prior spinal injections in the same region

Spondyloarthropathy [8]

ALL of the following must be met:

- The individual has experienced ≥ 3 months of low back pain
- Age of onset < 45 years
- Comprehensive pain management program is in place including physical therapy, home exercise, patient education, psychosocial support, and/or oral medication
- Prior history of evidence of sacroiliitis on imaging (i.e., active inflammation on magnetic resonance imaging [MRI] or definite radiographic sacroiliitis grade 2-4 bilaterally or grade 3-4 unilaterally)
- **1 or more** spondyloarthropathy features:
  - Inflammatory back pain evidence with **at least 4** of the following criteria present [9]:
    - Age at onset < 40 years
    - Insidious onset
    - Improvement with exercise
    - No improvement with rest
    - Pain at night (with improvement upon getting up)
  - Arthritis
  - Enthesitis of the heel (irritability of muscles, tendons, or ligaments where they enter the bone)
  - Uveitis (inflammation of the uvea, the middle layer of the eye)
  - Dactylitis (inflammation of a finger or toe)
  - Psoriasis
  - Crohn's/colitis
  - Good response to NSAIDs
  - Family history of spondyloarthropathy
  - Positive testing for HLA-B27
  - Elevated C-reactive protein (CRP)

Imaging Guidance [3,4]

- The sacroiliac joint is commonly identified under image guidance by Fluoroscopy or Computed tomography (CT). CT is less effective than Fluoroscopy regarding observing of the escape of the injectate to the adjacent structures and cannot rule out concurrent intravascular flow. With proper use by skilled interventional pain physicians with ultrasound experience, the use of ultrasound guidance is similar to CT or Fluoroscopy but can have a lower accuracy of needle placement.
- Ultrasound guidance can be an effective alternative if fluoroscopy or CT guided

techniques are contraindicated or when radiation exposure is problematic; however, individual patient factors such as poor visualization due to deeper tissue layers (e.g., increased Body Mass Index (BMI) may contribute to substandard image resolution).

NOTE: **ALL** procedures must be performed under imaging guidance

Diagnostic Purposes for Surgical Planning [3,6]

For diagnostic purposes, all the following must be met:

- The sacroiliac joint injection is an image-guided, contrast-enhanced intra-articular injection
- At least 75% pain relief for the expected duration of the anesthetic after each diagnostic injection
- After the diagnostic relief period, the individual continues to have pain causing functional disability or average pain level ≥ 6 on a scale of 0 to 10 related to the requested spinal region.
- No more than two diagnostic injections per diagnostic phase
- Documentation of a pre-operative evaluation and plan for SIJ surgery

Repeat Injections [1,3,6]

Sacroiliac joint injections may be repeated only as **Medical Necessity**. **Each** sacroiliac joint injection requires an authorization, and the following criteria must be met for repeat injections:

Initial Treatment Phase

- Up to 2 sacroiliac joint injections may be performed in the initial treatment phase, no sooner than 2 weeks apart, provided that at least 50% pain relief or significant documented functional improvement is obtained

Therapeutic Phase

- Sacroiliac joint injections may only be repeated after the initial treatment phase if the individual has had at least 50% pain relief or significant documented functional improvement for a **minimum of 2 months** before each therapeutic injection
- The individual continues to have pain causing functional disability or average pain level ≥ 6 on a scale of 0 to 10 related to the requested spinal region
- The individual is engaged in ongoing active conservative treatment unless the medical reason this treatment cannot be done is clearly documented
- For individuals that have received other interventional pain injections in the lumbar/sacral region (e.g., epidural steroid injection or facet joint injection) since the last SIJ injection, at least one repeat positive provocative exam finding is required (pelvic (SI) distraction test, pelvic (SI) compression test, sacral thrust test, FABER (Patrick's test), posterior shear test, Yeoman's test, Gaenslen's test, or thigh thrust)
- A maximum of 4 sacroiliac joint injections may be performed in a 12-month period per region in the therapeutic phase

EXCLUSIONS

These requests are excluded from consideration under this guideline:

- Sacral lateral branch blocks (S1, S2, S3)
- Radiofrequency denervation of the sacroiliac joint

CONTRAINDICATIONS [2,3,4]

- Absolute contraindications:
  - Active systemic or spinal infection
  - Skin infection at the site of needle puncture
  - Local malignancy
  - Septic joint
- Relative contraindications:
  - Coagulopathy
  - Pregnancy
  - Uncontrollable Diabetes
  - Current and uninterrupted use of blood-thinning medication

LEGISLATIVE LANGUAGE

Washington

20160318B – Spinal Injections [10]

Number and Coverage Topic:

20160318B – Spinal Injections

HTCC Coverage Determination:

Spinal injections are a **covered benefit with conditions**.

HTCC Reimbursement Determination:

Limitations of Coverage:*

- Therapeutic epidural injections in the lumbar or cervical-thoracic spine for chronic pain are a covered benefit when all of the following conditions are met: *ƒ*
  - For treatment of radicular pain; *ƒ*
  - With fluoroscopic guidance or CT guidance; *ƒ*
  - After failure of conservative therapy; *ƒ*
  - No more than two without clinically meaningful improvement in pain and function; and
  - Maximum of three in six months.

- Therapeutic sacroiliac joint injections for chronic pain is a covered benefit when all of the following conditions are met: ƒ
  - With fluoroscopic guidance or CT guidance; ƒ
  - After failure of conservative therapy; and ƒ
  - No more than one without clinically meaningful improvement in pain and function, subject to agency review.

* This coverage policy does not apply to those with a known systemic inflammatory disease such as: ankylosing spondylitis, psoriatic arthritis or enteropathic arthritis.

Non-Covered Indicators:

Therapeutic medial branch nerve block injections, intradiscal injections and facet injections are not a covered benefit.

CODING AND STANDARDS

Coding

CPT Codes

27096, G0260

Applicable Lines of Business

☒	CHIP (Children's Health Insurance Program)
☒	Commercial
☒	Exchange/Marketplace
☒	Medicaid
☒	Medicare Advantage

BACKGROUND

Definitions

Low back pain originating from the SIJ can result from inflammatory conditions such as sacroiliitis, spondyloarthropathy (e.g., ankylosing spondylitis, rheumatoid spondylitis), or from postsurgical or traumatic injury, degeneration (wear and tear), or pregnancy. SIJ pain most often occurs in the buttocks and lower back and may radiate down through the buttocks and the leg. Physical examination and radiographic techniques may confirm a diagnosis related to spondyloarthropathy. Physical examination, including provocative maneuvers to elicit pain response, and controlled SIJ injections can help diagnose noninflammatory pain arising from the SIJ.

Risks associated with SIJ dysfunction [3,4]:

- Gait abnormalities
- Scoliosis
- Leg-length discrepancies
- Inflammatory spondyloarthropathies, including ankylosing spondylitis
- Previous spine surgeries
- Connective tissue disorders (e.g., Ehlers–Danlos syndrome)
- Pregnancy associated with ligamentous laxity and hypermobility
- Obesity

Spinal injections for the treatment of SIJ pain syndrome are typically performed as one part of a comprehensive treatment program, but initial treatment usually includes over-the-counter analgesics, home exercise program to improve or maintain spinal mobility, and therapy sessions with a physical therapist involving range-of-motion, stretching, and strengthening exercises.

Sacroiliac joint injections are typically used for the following conditions:

- **Sacroiliac joint (SIJ) syndrome** may be caused by various events, including pain secondary to postsurgical or traumatic injury, degeneration (wear and tear), or pregnancy.
- **Diagnostic SIJ injections** are used to determine if the SIJ pain originates with the SIJ. Diagnostic blocks can reveal (or fail to reveal) that the source of pain is originating from the SIJ; appropriate treatment plan can be developed.
- **Therapeutic SIJ injections** used to treat SIJ pain once it has been determined that the SIJ is the origin of the pain. A therapeutic injection typically includes a corticosteroid and a local anesthetic that can be injected directly into the joint (intra-articular) or into the tissues surrounding the joint (periarticular).
- **Spondyloarthropathy** (also known as spondyloarthritis) is the name for a family of rheumatic diseases that cause arthritis. Sacroiliitis is a key indicator of spondyloarthritis and is diagnosed with imaging. Individuals with spondyloarthropathy are generally managed by rheumatologists.

The indications for coverage for the treatment of spondyloarthropathy have been established through criteria developed by the Assessment of SpondyloArthritis International Society (ASAS) for the classification of axial spondyloarthritis. [(11)] They are in keeping with the benefit guidelines developed by the Centers for Medicare & Medicaid Services (CMS). [(12)]

Telehealth visits have become routine in modern medical practice. However, sacroiliac joint injections cannot be performed via telehealth encounters. Individuals who can schedule an in- person encounter for injection are expected to also schedule an in-person encounter for provocative physical examination, prior to injection, in order to document the medical necessity of the joint injection.

Medical Necessity

It is generally considered not medically necessary to perform multiple interventional pain procedures on the same date of service. Documentation of a medical reason to perform injections in different regions on the same day can be provided and will be considered on a

case-by-case basis (e.g., holding anticoagulation therapy on two separate dates creates undue risk for the patient).

Home Exercise Program (HEP)** [13]

The following two elements are required to meet conservative therapy guidelines for HEP:

- Documentation of an exercise prescription/plan provided by a physician, physical therapist, or chiropractor

AND

- Follow-up documentation regarding completion of HEP after the required 6-week timeframe or inability to complete HEP due to a documented medical reason (e.g., increased pain or inability to physically perform exercises).

POLICY HISTORY

Date	Summary
December 2024	• This guideline replaces Evolent Clinical Guideline 305 for Sacroiliac Joint Injections • Clarified between initial and therapeutic treatment phase in Repeat Injections section • Added and categorized contraindications • Updated age onset limitation for inflammatory back pain in Spondyloarthropathy section • Included the full WA bill • Removed Conservative Treatment section in Background • Added risks of SIJ dysfunction information in Background
January 2024	• Added Legislative Language for the State of Washington • Updated provocation test to 3 to reflect EBM • Removed Anterior Impingement Test and Log roll as provocation tests • Added section on imaging guidance • Added diagnostic section to repeat injections • Added clarification to VAS section to include ‘related to the requested spinal region’ • Added Local Malignancy and removed Prolotherapy from contraindications section • Adjusted conservative treatment language in the body and background sections • Updated CPT Codes per the Matrix

Date	Summary
	• Reduced background section • Added table of contents • Updated references

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Specialty Clinical Guideline Review Committee

Disclaimer

Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.

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Evolent Clinical Guideline 1752 for Implantable Infusion Pump Insertion

Guideline Number: Evolent_CG_1752	**Applicable Codes**	
"Evolent" refers to Evolent Health LLC and Evolent Specialty Services, Inc. 		
Original Date: July 2015	**Last Revised Date:** December 2025	**Implementation Date:** July 2026

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STATEMENT

General Information

- *It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *The guideline criteria in the following sections were developed utilizing evidence-based and peer-reviewed resources from medical publications and societal organization guidelines as well as from widely accepted standard of care, best practice recommendations.*

Purpose

The purpose of this guideline is to address criteria for intraspinal drug trials as well as the permanent placement of an implantable infusion pump.

NOTE: There are no medical indications for intrathecal treatments except chronic pain and intractable spasticity. For information on multiple procedures performed in the same day of service, see **Medical Necessity**.

INDICATIONS FOR INTRASPINAL DRUG TRIAL

All patients colonized with methicillin-sensitive or methicillin-resistant Staphylococcus aureus (MRSA or MSSA) must have a decolonization plan to be performed no earlier than 10 days prior to the planned procedure. (1)

Chronic Intractable Pain in Non-Terminal Individuals

For the treatment of chronic intractable pain in non-terminal individuals (**ALL** the following criteria must be met):

- Pain causing functional disability that significantly interferes with activities of daily living, including ability to work and overall quality of life (2) **OR** persistent pain level of ≥ 6 on a scale of 0 to 10 despite treatment
- Failure to respond to non-operative conservative therapy targeting the requested spinal region for a minimum of 12 weeks unless the medical reason this treatment cannot be done is clearly documented

Spasticity in Non-Terminal Individuals

For the treatment of spasticity in non-terminal individuals (**ALL** the following must be met):

- Intractable spasticity that results in the individual's inability to maintain an upright posture, severely impairs balance in ambulation, or significantly interferes with activities of daily living related to **ONE** of the following conditions (3,4):

- Spinal cord injury
- Multiple sclerosis
- Stiff person syndrome
- Other medical conditions causing intractable spasms

- Failure to respond to a minimum of 12 weeks of non-operative conservative therapy (e.g., oral medications, physical therapy, etc.)

Additional Trials

A second intraspinal drug trial is indicated when documentation of the first trial of intraspinal (intrathecal or epidural) medication administered as a bolus or by continuous infusion resulted in one of the following:

- Less than 50% pain relief
- Intolerable side effects
- Limit of two intraspinal drug trials for preliminary consideration of chronic intractable pain or spasticity management with permanent implantable device in non-terminal individuals.

NOTE: Intrathecal trials are not indicated in opioid-naïve individuals

PERMANENTLY IMPLANTED INFUSION PUMP

Chronic Intractable Pain in Non-Terminal Individuals

For the treatment of chronic intractable pain in non-terminal individuals (**ALL** the following must be met):

- Pain causing functional disability that significantly interferes with activities of daily living, including ability to work and overall quality of life [(2)] **OR** persistent pain level of ≥ 6 on a scale of 0 to 10 despite treatment
- Failure to respond to non-operative conservative therapy targeting the requested spinal region for a minimum of 12 weeks unless the medical reason this treatment cannot be done is clearly documented
- At least 12 weeks of oral or transdermal opioid or nonopioid pain medications
- Documentation of a successful trial of intraspinal (intrathecal or epidural) medication administered as a bolus or by continuous infusion providing at least 50% pain relief with tolerable side effects
- Documentation of a completed psychological assessment prior to permanent pump insertion that documents the individual's cognitive ability, physical capability, and willingness to participate in implanted infusion pump therapy [(2)]

Spasticity in Non-Terminal Individuals

For the treatment of spasticity in non-terminal individuals (**ALL** of the following must be met):

- Intractable spasticity that results in the individual's inability to maintain an upright posture, severely impairs balance in ambulation, or significantly interferes with activities of daily living related to **one** of the following conditions [3,4]:
  - Spinal cord injury
  - Multiple sclerosis
  - Stiff person syndrome
  - Other medical conditions causing intractable spasms
- Failure to respond to a minimum of 12 weeks of conservative therapy (e.g., oral medications, physical therapy, etc.)
- Documentation of a successful trial of intraspinal (intrathecal or epidural) antispasmodic medication administered as a bolus or by continuous infusion providing at least 50% spasm relief with tolerable side effects
- Documentation of a completed psychological assessment prior to permanent pump insertion that documents the individual's cognitive ability, physical capability, and willingness to participate in implanted infusion pump therapy

PUMP REPLACEMENT, REVISION AND REMOVAL

Replacement, revision, or removal of an Implanted Infusion Pump is indicated with any of the following:

- Loss of effectiveness (e.g., battery depletion)
- Intolerance by the individual
- Infection
  - A consultation with an infectious disease specialist is documented. [1]
  - There is a 12-week interval between removal of the infected device and implantation of the new device. [1]
  - It is strongly recommended that a nasal swab to test for *Staphylococcus aureus* and decolonization for positive patients be performed before revision due to surgical site infection. A medical reason why this cannot be performed must be clearly documented. [1]
- Painful generator site
- Patient demand
- Documentation of pump or catheter malfunction impairing function or safety
- Other medical reasons deemed appropriate for replacement, revision, or removal

NOTE: If the pump is programmable, the pump analysis report should accompany the request for replacement.

CONTRAINDICATIONS FOR IMPLANTED INFUSION PUMP

- Active systemic or spinal infection
- Body habitus that is insufficient to support the weight and bulk of the device

Note: It is strongly recommended that patients with a prior history of surgical site infection be tested for *Staphylococcus aureus* via nasal swab prior to surgery. (1)

CODING AND STANDARDS

Codes

CPT	
Code	**Description**
Implantable Infusion Pump Insertion	
62350	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy
62351	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; with laminectomy
62355	Removal of previously implanted intrathecal or epidural catheter
62360	Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir
62361	Implantation or replacement of device for intrathecal or epidural drug infusion; nonprogrammable pump
62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming

Applicable Lines of Business

☒	CHIP (Children's Health Insurance Program)
☒	Commercial
☒	Exchange/Marketplace
☒	Medicaid
☒	Medicare Advantage

BACKGROUND

Medical Necessity

It is generally considered **not medically necessary** to perform multiple interventional pain procedures on the same date of service. Documentation of a medical reason to perform injections in different regions on the same day can be provided and will be considered on a case-by-case basis (e.g., holding anticoagulation therapy on two separate dates creates undue risk for the patient). Different types of injections in the same spinal region (cervical, thoracic, or lumbar) should not be done on the same day with the exception of a facet injection and ESI (Epidural Spine Injection) performed during the same session for a synovial cyst confirmed on imaging.

SUMMARY OF EVIDENCE

The American Society of Pain and Neuroscience (ASPN) Evidence-Based Clinical Guideline of Interventional Treatments for Low Back Pain [(2)]:

- **Study Design**: This is an evidence-based clinical guideline developed by the American Society of Pain and Neuroscience (ASPN) for interventional treatments of low back pain.
- **Target Population**: Patients with low back pain, including those with lumbar spinal disorders.
- **Key Factors**: The guideline provides a comprehensive review of interventional treatments for low back pain, including epidural steroid injections, trigger point injections, facet interventions, and intradiscal regenerative therapies. It emphasizes the importance of evidence-based recommendations and the need for periodic updates to maintain relevance with current treatment standards.

Examining the effectiveness of intrathecal baclofen on spasticity in individuals with chronic spinal cord injury: A systematic review [(3)]:

- **Study Design**: This is a systematic review examining the effectiveness of intrathecal baclofen on spasticity in individuals with chronic spinal cord injury (SCI). The review included eight non-randomized controlled trials (non-RCTs) with a pooled sample size of 162 individuals.
- **Target Population**: Individuals with chronic SCI, at least six months post-injury or diagnosis, who received continuous intrathecal baclofen via an implantable pump.
- **Key Factors**: The review found substantial evidence that intrathecal baclofen is effective in reducing spasticity, with significant reductions in Ashworth scores and spasm frequency scores. The study also noted several complications related to the use of intrathecal baclofen or pump and catheter malfunction.

Best Practices for Intrathecal Baclofen Therapy: Patient Selection [4]:

- **Study Design**: This is a consensus guideline developed by an expert panel on best practices for intrathecal baclofen therapy, focusing on patient selection.
- **Target Population**: Patients with severe spasticity of spinal and cerebral origins, including children and adults with conditions such as multiple sclerosis, spinal cord injury, brain injury, cerebral palsy, and stroke.
- **Key Factors**: The guideline emphasizes the importance of considering intrathecal baclofen therapy when spasticity interferes with comfort, function, or caregiving. It also discusses contraindications, patient and family education, goal setting, and the need for a screening test before implantation.

ANALYSIS OF EVIDENCE

Shared Findings:

- Intrathecal baclofen is effective in reducing spasticity and managing pain in patients with severe spasticity and low back pain. [2–4]
- Proper patient selection, education, and goal setting are crucial for the success of intrathecal baclofen therapy. [2,4]
- Regular updates and adherence to evidence-based guidelines are essential to maintain the relevance and effectiveness of treatment protocols. [4]

Differing Findings:

- McIntyre et al 2014 provides a more detailed quantitative analysis of the effectiveness of intrathecal baclofen, while Saulino et al 2016 and Sayed et al 2022 offer broader guidelines and recommendations. [2–4]
- Saulino et al 2016 focuses on patient selection and education, while Sayed et al 2022 provides a comprehensive review of various interventional treatments for low back pain. [2,4]

POLICY HISTORY

Date	Summary
December 2025	• Updated headings, Disclaimer, and General Information • Infection regarding *Staphylococcus aureus* inserted in appropriate sections. • Added CPT code table to reflect new formatting. • Added Summary of Evidence and Analysis of Evidence
December 2024	• This guideline replaces Evolent Clinical Guideline 310 Implantable Infusion Pump Insertion
January 2024	• Added criteria for additional intrathecal trials • Expanded pump criteria to include non-opioid medical trials • Expanded replacement indications to also include revision and removal • Edited background

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Specialty Services Clinical Guideline Review Committee

Disclaimer

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Evolent Clinical Guidelines are comprehensive and inclusive of various procedural applications for each service type. Our guidelines may be used to supplement Medicare criteria when such criteria is not fully established. When Medicare criteria is determined to not be fully established, we only reference the relevant portion of the corresponding Evolent Clinical Guideline that is applicable to the specific service or item requested in order to determine medical necessity.

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Evolent Clinical Guideline 1757 for Spinal Cord Stimulation

Guideline Number: Evolent_CG_1757	**Applicable Codes**	
"Evolent" refers to Evolent Health LLC and Evolent Specialty Services, Inc.		
Original Date: August 2020	**Last Revised Date:** December 2025	**Implementation Date:** July 2026

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STATEMENT

General Information

- *It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *The guideline criteria in the following sections were developed utilizing evidence-based and peer-reviewed resources from medical publications and societal organization guidelines as well as from widely accepted standard of care, best practice recommendations.*

Special Note

- Code 63650 is also applicable for dorsal root ganglion stimulation (DRG). DRG has specific advantages over SCS as it has better CRPS coverage and greater anatomical specificity allowing for improved coverage for specific areas of the body, such as pain in the foot, knee, hip, and groin — areas noted to be difficult for SCS. [(1)]
- For individuals with chronic pain who have failed conservative approaches, SCS should be considered among other options before prescribing long-term opioids. [(2)]

INDICATIONS

All patients colonized with methicillin-sensitive or methicillin-resistant *Staphylococcus aureus* (MRSA or MSSA) must have a decolonization plan to be performed no earlier than 10 days prior to the planned procedure.

Spinal Cord Stimulation

A spinal cord stimulation (SCS) trial is appropriate when **ALL** the following criteria are met:

- Pain that:
  - Is causing functional disability or average pain level of ≥ 6 on a scale of 0 to 10 [(3)]
  - Is of at least 6 months duration [(3)]
  - Is caused by at least one of the following [(2,3)]:
    - Failed spine surgery syndrome (FSSS)/persistent spinal pain syndrome (PSPS) or post-laminectomy syndrome [(4)]
    - Complex regional pain syndrome (CRPS), type I or type II, meeting Budapest criteria
    - Chronic neuropathic pain of certain origins that falls into **ONE** of the following diagnoses:

- □ Lumbosacral arachnoiditis
- □ Post herpetic neuralgia
- □ Radiculopathy
- □ Chronic ischemic leg pain
- □ Diabetic peripheral neuropathy [5]
- □ Phantom limb syndrome (stump pain)
- □ Peripheral neuropathy
- □ Chronic back pain (neuropathic pain) and not a surgical candidate
- □ Chronic, refractory angina pectoris, characterized by **ALL** the following:
  - ◆ Continued angina after percutaneous coronary intervention or coronary artery bypass graft
  - ◆ Not a candidate for further revascularization
  - ◆ Angina is NYHA (New York Heart Association) III (less than ordinary physical activity causes symptoms) or IV (symptoms present at rest)
  - ◆ Optimal pharmacotherapy for at least one month with failure to tolerate medications in indicated dosage or failure to respond adequately to indicated medications

- Failure to respond to non-operative conservative treatment (e.g., medication trials, interventional procedures (e.g., sympathetic nerve blocks, epidural steroid injections)) for a minimum of 6 months unless the medical reason this treatment cannot be done is clearly documented [6]
- A completed presurgical psychological assessment that documents the following [2,3]:
  - Pain is not due to psychiatric disorders such as depression, anxiety, somatic symptom disorder, or sequelae of substance use
  - Satisfactory management of personality and psychiatric disorders
  - Satisfactory management of substance use disorder in recovery
  - Demonstration of cognitive ability to manage the stimulator

Dorsal Root Ganglion Stimulator

A dorsal root ganglion stimulation (DRGS) trial is appropriate when **ALL** the following criteria are met:

- Pain that:
  - Is causing functional disability or average pain level of ≥ 6 on a scale of 0 to 10 [3]
  - Duration of at least 6 months [3]
  - Is caused by complex regional pain syndrome (CRPS) affecting the lower limbs, type I or type II, meeting Budapest criteria

- Failure to respond to non-operative conservative treatment (e.g., medication trials, interventional procedures (e.g., sympathetic nerve blocks, epidural steroid injections)) for a minimum of 6 months unless the medical reason this treatment cannot be done is clearly documented [6]
- A completed presurgical psychological assessment that documents the following [2,3]:
    - Pain is not due to psychiatric disorders such as depression, anxiety, somatic symptom disorder, or sequelae of substance use
    - Satisfactory management of personality and psychiatric disorders
    - Satisfactory management of substance use disorder in recovery
    - Demonstration of cognitive ability to manage the stimulator

Permanent Spinal Cord or Dorsal Root Ganglion Stimulator [2]

Appropriate when **ALL** the following criteria are met:

- Documentation of a successful trial of the temporary SCS device providing at least 50% reduction in pain
- Significant functional improvement for a minimum duration of 3 days
- Following a device-related non-superficial infection IF:
    - A consultation with an infectious disease specialist is documented
    - There is a minimum 12-week interval between removal of the infected device and implantation of the new device

NOTE: A medical reason for use of a permanent stimulator device different from the temporary trial device must be clearly documented

Revision or Removal of Spinal Cord or Dorsal Root Ganglion Stimulator Device

Indicated with **ONE** of the following:

- Migration of lead(s)
- Loss of effectiveness
- Intolerance by the individual
- Infection
    - A consultation with an infectious disease specialist is documented
    - There is a minimum 12-week interval between removal of the infected device and implantation of the new device
    - It is strongly recommended that a nasal swab to test for *Staphylococcus aureus* and decolonization for positive patients be performed before revision due to surgical site infection. A medical reason why this cannot be performed must be clearly documented.

- Painful generator site
- Development of neurological deficits
- Patient demand

CONTRAINDICATIONS [3]

- Active systemic or spinal infection
- Body habitus that is insufficient to support the weight and bulk of the device
- Coagulation disorder
- Pregnancy

Note: It is strongly recommended that patients with a prior history of surgical site infection be tested for *Staphylococcus aureus* via nasal swab prior to surgery.

CODING AND STANDARDS

Codes

CPT	
Code	**Description**
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
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

CPT	
Code	**Description**
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

Applicable Lines of Business

☒	CHIP (Children's Health Insurance Program)
☒	Commercial
☒	Exchange/Marketplace
☒	Medicaid
☒	Medicare Advantage

BACKGROUND

Medical Necessity

It is generally considered not medically necessary to perform multiple interventional pain procedures on the same date of service. Documentation of a medical reason to perform procedures in different regions on the same day can be provided and will be considered on a case-by-case basis.

Home Exercise Program (HEP)** (7)

The following two elements are required to meet conservative therapy guidelines for HEP:

- Documentation of an exercise prescription/plan provided by a physician, physical therapist, or chiropractor **AND**
- Follow-up documentation regarding completion of HEP after the required 6-week timeframe or inability to complete HEP due to a documented medical reason (e.g., increased pain or inability to physically perform exercises).

SUMMARY OF EVIDENCE

Appropriate Referral and Selection of Patients with Chronic Pain for Spinal Cord Stimulation: European Consensus Recommendations and E-Health Tool [3]

Study Design:

- Multidisciplinary European consensus panel using the RAND/UCLA Appropriateness Method (RUAM), a modified Delphi technique.
- Combined evidence from clinical studies and expert opinion to assess appropriateness of spinal cord stimulation (SCS) for 386 clinical scenarios across four pain areas.

Target Population:

- Adults (≥18 years) with chronic pain (≥6 months) and moderate or greater pain severity (VAS ≥5) impacting daily function and quality of life.
- Four main indications: chronic low back/leg pain, complex regional pain syndrome (CRPS), neuropathic pain syndromes, and ischaemic pain syndromes.

Key Factors:

- Inclusion: insufficient response to medications/minimally invasive treatments, no expected benefit from surgery.
- Exclusion: unwillingness or inability to manage an implant, absolute contraindications (e.g., infection, coagulation disorder), uncontrolled psychiatric disorder, ongoing substance abuse, widespread pain.
- Psychosocial factors (e.g., engagement, coping, expectations, social support, psychological distress, opioid use) were systematically evaluated.
- Developed an educational e-health tool integrating clinical and psychosocial factors for referral/selection.
- Results: Appropriateness of SCS was strongly determined by pain type (neuropathic/neuropathic-like), location, anatomical abnormalities, and previous response to pain-targeted therapies. Psychosocial factors were also critical.
- Conclusions: RUAM helped establish patient-specific criteria for SCS referral/selection; recommendations are available as an e-health tool for clinicians.

Evidence-based Consensus Guidelines on Patient Selection and Trial Stimulation for Spinal Cord Stimulation Therapy for Chronic Non-cancer Pain [2]

Study Design:

- Multispecialty, multisociety consensus guidelines developed via a modified Delphi method.
- Comprehensive literature review and evidence synthesis, with 100% consensus on 39 recommendations across seven sections.

Target Population:

- Patients with chronic non-cancer pain considered for spinal cord stimulation (SCS).

- Specific pain indications: chronic low back/leg pain, critical limb ischemia, painful diabetic neuropathy, complex regional pain syndrome (CRPS), and chronic anginal pain.

Key Factors:

- SCS trial recommended before definitive implant for most indications (except anginal pain).
- All patients must be screened for psychosocial factors (especially depression) using validated instruments.
- Absolute contraindications: active psychosis, ongoing substance abuse.
- Other predictors: high BMI, current smoking, high opioid use, benzodiazepine use, poor coping/self-efficacy, poor social support, catastrophizing, anxiety, PTSD.
- SCS trial: typically percutaneous leads, 5–7 days duration, with evaluation of pain relief (≥50%), functional improvement, tolerability, and patient understanding.
- Recommendations emphasize individualized patient education, realistic expectations, and multidisciplinary assessment.
- Conclusions: These guidelines provide a pragmatic, evidence-based framework for patient selection and trial conduct in SCS therapy, but should not be enforced as rigid standards.

The Neurostimulation Appropriateness Consensus Committee (NACC): Recommendations on Best practices for Cervical Neurostimulation [(6)]

Study Design:

- Consensus guidance from the American Society of Pain and Neuroscience (ASPN) for minimally invasive lumbar spinal stenosis treatment (MIST).
- Systematic literature review and evidence grading using USPSTF criteria; expert panel consensus for best practice.

Target Population:

- Patients with symptomatic lumbar spinal stenosis (LSS), especially those with neurogenic claudication.
- Subgroups: mild-to-moderate LSS, moderate degenerative LSS, and those with comorbidities limiting open surgery.

Key Factors:

- Treatments reviewed: percutaneous image-guided lumbar decompression (PILD), interspinous spacers/fusion, intrathecal drug delivery systems (IDDS), open decompression, neurostimulation (SCS), and epidural steroid injections (ESI).
- PILD: indicated for central stenosis due to ligamentum flavum hypertrophy (≥2.5 mm), grade ≤2 spondylolisthesis, and neurogenic claudication.
- Interspinous spacers: for moderate LSS, grade ≤1 spondylolisthesis, absence of instability, after failure of conservative management.

- SCS: considered for intractable pain of trunk/limbs, including LSS, after failure of other treatments.
- Contraindications: prior surgery at index level, infection, severe osteoporosis, instability, psychiatric disorder, inability to comply, active infection.
- Literature review includes RCTs, prospective/retrospective studies, meta-analyses, and case series supporting efficacy and safety of minimally invasive treatments.
- Conclusions: ASPN guidance provides an evidence-based algorithm for minimally invasive and surgical treatments of LSS, emphasizing patient selection, safety, and efficacy.

ANALYSIS OF EVIDENCE

- Comparison of the research findings demonstrate several points of consensus: Careful patient selection is critical for SCS success [2,3,6]:
    - Appropriateness is determined by pain type, location, anatomical abnormalities, previous treatment response, and psychosocial factors. Developed an e-health tool to guide selection.
    - Recommend systematic psychosocial screening (especially for depression), and highlights the need for individualized education and expectation management. Absolute contraindications include active psychosis and ongoing substance abuse.
    - Stresses the need for anatomical and clinical assessment, and contraindications such as psychiatric disorder, inability to comply, or infection.
- Psychosocial factors are major determinants of SCS outcomes. [2,3,6]
- SCS is an established therapy for select chronic pain conditions, but optimal outcomes depend on rigorous patient selection, including both clinical and psychosocial factors. [2,3,6]
- There is consensus that SCS trial stimulation is valuable for most indications, and that psychosocial screening (especially for depression and substance abuse) is essential. [2,3,6]
- The evidence base is robust for some indications (e.g., failed back surgery syndrome, CRPS), but less so for others (e.g., ischemic pain, LSS), where expert consensus and individualized assessment are especially important. [2,3,6]

In summary, the evidence across these three authoritative sources converges on the importance of individualized, multidisciplinary, and evidence-informed patient selection for SCS. While there is strong support for SCS in certain chronic pain populations, ongoing research and consensus-building are needed to refine indications, optimize outcomes, and ensure patient safety.

POLICY HISTORY

Date	Summary
December 2025	• Clarified indications for permanent device • Added second bullet to General Information • Reordered pain indications • Added Summary of Evidence and Analysis of Evidence per Medicare requirements
December 2024	• This guideline replaces Evolent Clinical Guideline 405 for Spinal Cord Stimulation • Added Special Note section for CPT code 63650 • Added 6-month pain duration and psychiatric disorder in SCS indication section • Condensed complex regional pain syndrome (CRPS) characteristics to "Complex regional pain syndrome types I and II, meeting Budapest criteria" for consistency with the Sympathetic Nerve Blocks guideline • Clarified the last indication of Permanent Spinal Cord Stimulator section: "The type of stimulator device used for temporary trial will be the same used for permanent spinal cord stimulator placement" to "A medical reason for use of a permanent stimulator device from the temporary trial device must be clearly documented" • Added "coagulation disorder" and "pregnancy" to Contraindication section • Added Medical Necessity section • Removed Conservative Treatment section in Background

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Specialty Services Clinical Guideline Review Committee

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Evolent Clinical Guideline 1758 for Sympathetic Nerve Blocks

Guideline Number:	Applicable Codes	
Evolent_CG_1758		
"Evolent" refers to Evolent Health LLC and Evolent Specialty Services, Inc. 		
Original Date:	**Last Revised Date:**	**Implementation Date:**
November 2020	December 2025	July 2026

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STATEMENT

General Information

- *It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *The guideline criteria in the following sections were developed utilizing evidence-based and peer-reviewed resources from medical publications and societal organization guidelines as well as from widely accepted standard of care, best practice recommendations.*

Purpose

This guideline focuses on the utilization management of sympathetic nerve blocks for the diagnosis and acute and chronic management of sympathetically maintained pain for specific indications.

Special Note

Sympathetically maintained pain is a symptom of neuropathic pain. The pain is driven by overactivity of the sympathetic nervous system with or without an identifiable injury and is notably characterized as a clinical syndrome called complex regional pain syndrome (CRPS); but may also occur from neuropathic pain syndromes of different etiologies. Sympathetic nerve blocks provide diagnostic value in the identification of sympathetically maintained pain and the focused location of nerves along the spinal column provide a targeted advantage. These blocks are widely used in both acute and chronic management of sympathetically maintained pain of visceral, ischemic, and neuropathic etiologies.

New Episodes of Care

Any injection performed at least two years from prior injections in the same region will be considered a new episode of care and the **INITIAL** injection requirements must be met for approval. Events such as surgery on the same spinal region or any new pathology would also prompt a new episode of care.

INDICATIONS

General Indications

- Acute or chronic noncancer pain causing functional disability or average pain level of ≥ 6 on a scale of 0 to 10 prior to injection **AND** continuation of pain or functional disability after the relief period due to the block
- Cancer pain affecting quality of life prior to injection and continuation after the relief

period due to the block [1]

NOTE: It is generally considered **not medically necessary** to perform multiple interventional pain procedures on the same date of service (e.g., diagnostic block and neurolytic procedure)

NOTE: Each block must be performed under image guidance [2]

Indications for Stellate Ganglion Block

Applies to face, upper extremities and upper thoracic region

Diagnostic Evaluation or Acute Management of Sympathetically Maintained Pain

For pain resulting from:

- Acute Herpes Zoster (shingles) for prevention of postherpetic neuralgia [3–5] **AND**
  - Pain duration less than 4 weeks, **AND**
  - Active antiviral therapy regimen or documented medical reason unable to tolerate
- Cancer pain or phantom limb pain [2] **AND**
- Failure to respond to nonoperative conservative treatment pertinent to the diagnosis or a clearly documented medical reason the conservative treatment cannot be done
- The previous block resulted in at least 50% relief or significant documented functional improvement for at least the duration of the anesthetic

NOTE: Up to 6 sympathetic blocks may be performed per 12 months

Diagnostic Evaluation, Acute or Chronic Management of Sympathetically Maintained Pain

For pain resulting from:

- Complex regional pain syndrome types I [4,6] and II [7] meeting Budapest criteria, **AND**
  - Failure to respond to functional restoration modalities which may include physical therapy, occupational therapy, or pain psychology modalities (e.g. rehabilitation strategies such as desensitization, range of motion, biofeedback, etc) or clearly documented medical reason the patient is unable to participate
  - Active participation in ongoing functional restoration or a clearly documented medical reason the treatment cannot be done [2]
- The previous block resulted in at least 50% relief or significant documented functional improvement for at least the duration of the anesthetic

NOTE: During the initial treatment phase, a total of 6 blocks may be performed within the first 12 weeks. Following the initial treatment phase, a maximum of 4 sympathetic nerve blocks may be performed in a 12-month period

General Limitations

- It has been at least one week since the prior injection in the same or different region
- Bilateral stellate ganglion blocks will not be performed on the same day of service

Contraindications

- Patient refusal
- Local or systemic infection
- Coagulopathy or recent myocardial infarction
- Contralateral pneumothorax or severe emphysema
- Contralateral palsy of recurrent laryngeal nerve or phrenic nerve
- Allergy to anesthetic medication

Indications for Thoracic or Lumbar Sympathetic Block

Applies to thoracic region and lower extremities

Diagnostic Evaluation or Acute Management of Sympathetically Maintained Pain

For pain resulting from:

- Acute Herpes Zoster (shingles) for prevention of postherpetic neuralgia [3,8] **AND**
  - Pain duration less than 4 weeks, **AND**
  - Active antiviral therapy regimen or documented medical reason unable to tolerate
- Cancer pain, phantom limb pain, or nonsurgical ischemic limb pain [2] **AND**
  - Failure to respond to nonoperative conservative treatment pertinent to the diagnosis or a clearly documented medical reason the conservative treatment cannot be done
- The previous block resulted in at least 50% relief or significant documented functional improvement for at least the duration of the anesthetic

NOTE: Up to 6 sympathetic blocks may be performed per 12 months.

Diagnostic Evaluation, Acute or Chronic Management of Sympathetically Maintained Pain

For pain resulting from:

- Complex regional pain syndrome types I and II [6,9] meeting Budapest criteria, **AND**
  - Failure to respond to functional restoration modalities which may include physical therapy, occupational therapy, or pain psychology modalities (e.g. rehabilitation strategies such as desensitization, range of motion, biofeedback, etc) or clearly documented medical reason the patient is unable to participate

- Active participation in ongoing functional restoration or a clearly documented medical reason the treatment cannot be done [2]

- The previous block resulted in at least 50% relief or significant documented functional improvement for at least the duration of the anesthetic

NOTE: During the initial treatment phase, a total of 6 blocks may be performed within the first 12 weeks. Following the initial treatment phase, a maximum of 4 sympathetic nerve blocks may be performed in a 12-month period

General Limitations

- It has been at least one week since the prior injection in the same or different region
- Bilateral thoracic or lumbar sympathetic blocks will not be performed on the same day
- Imaging modalities do not include ultrasound guidance

Contraindications

- Patient refusal
- Local or systemic infection
- Coagulopathy, hypotension or recent myocardial infarction
- Contralateral pneumothorax
- Allergy to anesthetic medication

Indications for Celiac Plexus Block

Applies to the upper abdomen

For The Diagnostic Evaluation of Sympathetically Maintained Visceral Pain

- Upper abdominal pain associated with malignancy [9]
  - Conservative treatment is not required
- Up to two diagnostic blocks may be performed in the initial diagnostic phase for a planned neurolysis procedure

For the Acute or Chronic Management of Sympathetically Maintained Visceral

For pain resulting from:

- Chronic, relapsing pancreatitis [2,9] **AND**
  - Failure to respond to nonoperative conservative treatment pertinent to the diagnosis or a clearly documented medical reason the conservative treatment cannot be done
- If the first injection is unsuccessful, a second initial injection may be performed in the

initial phase for a maximum of 2 injections.

- After the initial phase, a therapeutic block may be performed every 3 months in a 12-month period
- The previous block resulted in at least 50% relief or significant documented functional improvement for at least the duration of the anesthetic
- Each therapeutic block resulted in at least 50% relief for a duration of 3 months

General Limitations

- At least one week between diagnostic blocks or injections performed in the initial phase

Contraindications

- Patient refusal
- Local or systemic infection
- Coagulopathy, hypotension or recent myocardial infarction
- Contralateral pneumothorax
- Allergy to anesthetic medication
- Abnormal anatomy

Indications for Superior Hypogastric Block

Applies to the pelvic and rectal regions

For The Diagnostic Evaluation of Sympathetically Maintained Visceral Pain

- Pelvic or rectal pain associated with malignancy [(9)]
  - Conservative treatment is not required
- Up to two diagnostic blocks may be performed in the initial diagnostic phase for a planned neurolysis procedure

For the Acute or Chronic Management of Sympathetically Maintained Visceral Pain

For pain resulting from:

- Chronic noncancer pain of pelvic and rectal viscera [(10)] **AND**
  - Failure to respond to nonoperative conservative treatment pertinent to the diagnosis or a clearly documented medical reason the conservative treatment cannot be done
- If the first injection is unsuccessful, a second initial injection may be performed in the initial phase for a maximum of 2 injections.

- After the initial phase, a therapeutic block may be performed every 3 months in a 12-month period
- The previous block resulted in at least 50% relief or significant documented functional improvement for at least the duration of the anesthetic
- Each therapeutic block resulted in at least 50% relief for a duration of 3 months

General Limitations

- At least one week between diagnostic blocks or injections performed in the initial phase
- Imaging modalities do not include ultrasound guidance

Contraindications

- Patient refusal
- Local or systemic infection
- Coagulopathy, hypotension or recent myocardial infarction
- Allergy to anesthetic medication
- Abnormal anatomy

Exclusions

These requests are excluded from consideration under this guideline:

- Sphenopalatine ganglion block
- Ganglion impar block
- Other parasympathetic ganglion blocks
- Inferior hypogastric block

CODING AND STANDARDS

Codes

CPT	
Code	**Description**
64510	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)
64517	Injection, anesthetic agent; superior hypogastric plexus

CPT	
Code	**Description**
64520	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)
64530	Injection, anesthetic agent; celiac plexus, with or without radiologic monitoring

Applicable Lines of Business

☒	CHIP (Children's Health Insurance Program)
☒	Commercial
☒	Exchange/Marketplace
☒	Medicaid
☒	Medicare Advantage

SUMMARY OF EVIDENCE

Effects of Applying Nerve Blocks to Prevent Postherpetic Neuralgia in Patients with Acute Herpes Zoster: A Systematic Review and Meta-Analysis [(3)]
Study Design:

- Systematic review and meta-analysis of 9 randomized controlled trials (RCTs) (n=1,645).
- Included studies enrolled patients with acute herpes zoster within 2–3 weeks of rash onset.
- Compared nerve blocks (local anesthetics/steroids) plus standard therapy vs. standard therapy or placebo.

Target Population:

- Adults with acute herpes zoster, mostly older adults (many studies included patients >50 years).

Key Findings & Factors:

- Repeated/continuous epidural and paravertebral blocks significantly reduced the incidence of postherpetic neuralgia (PHN) at 3, 6, and 12 months.
- Stellate ganglion block and single epidural injection did not show significant benefit for PHN prevention.

- No serious adverse events reported; minor events were transient.
- Heterogeneity in block techniques and outcome measures; most studies were single-center with small sample sizes.

Interventional Treatment of Complex Regional Pain Syndrome [6]

Study Design:

- Narrative review of interventional treatments for complex regional pain syndrome (CRPS), including sympathetic nerve blocks.
- Summarizes RCTs, cohort studies, and meta-analyses.

Target Population:

- Patients with CRPS (Types I and II), typically with chronic, refractory pain disproportionate to injury.

Key Findings & Factors:

- Sympathetic blocks (stellate/lumbar) can provide significant pain relief and functional improvement in CRPS, but results vary.
- Retrospective cohort: 61% of CRPS patients had >50% pain reduction after sympathetic block; most relief lasted 1–4 weeks.
- RCT: Botulinum toxin added to lumbar sympathetic block prolonged temperature increase and pain relief vs. local anesthetic alone.
- Limitations: Small sample sizes, lack of controls, technical variability, and short follow-up.
- Chemical/surgical sympathectomy is reserved for refractory cases; evidence is limited and complications are significant.
- Safety: Generally safe with minor, transient adverse events.

Practice Guidelines for Chronic Pain Management [2]

Study Design:

- Practice guideline developed by expert consensus and systematic literature review.
- Aggregates evidence from RCTs, observational studies, and expert surveys.

Target Population:

- Adults with chronic non-cancer pain, especially those with neuropathic pain syndromes or CRPS.

Key Findings & Factors:

- Sympathetic blocks may be used for CRPS as part of multimodal therapy if consistent improvement and increasing duration of pain relief are observed.
- Not recommended for long-term treatment of non-CRPS neuropathic pain.

- Evidence for long-term efficacy is insufficient; most studies are observational or short-term.
- Safety: Generally safe; insufficient long-term data.
- Recommendations are graded by evidence strength and consensus.

ANALYSIS OF EVIDENCE

Comparison of the research demonstrates the following shared findings [2,3,6]:

- **Short-term Pain Relief**: Sympathetic nerve blocks (stellate/lumbar) can provide significant short-term pain relief for select neuropathic pain syndromes, especially CRPS and acute herpes zoster.
- **Technique Matters**: Repeated or continuous blocks (epidural, paravertebral) are more effective than single injections for both PHN prevention and CRPS pain relief.

Findings specific to nerve block include:

- **Herpetic Neuralgia**: Meta-analysis shows that repeated/continuous epidural and paravertebral blocks significantly reduce PHN incidence at 3, 6, and 12 months. Stellate ganglion block and single epidural injection do not show significant benefit for PHN prevention. [3]
- **CRPS**: Sympathetic blocks can provide >50% pain reduction in 61% of CRPS patients, but relief is typically short-lived (1–4 weeks). Addition of botulinum toxin may prolong benefit. Evidence for chemical/surgical sympathectomy is limited and complications are significant. [6] Sympathetic blocks may be used for CRPS if consistent improvement and increasing duration of pain relief are observed. Not recommended for long-term treatment of non-CRPS neuropathic pain due to insufficient evidence. [2]

In conclusion [2,3,6]:

- Sympathetic nerve blocks are most effective for short-term pain relief in CRPS and for PHN prevention when repeated/continuous techniques are used.
- Long-term efficacy is uncertain, especially outside CRPS.
- Safety profile is favorable for most blocks, but more invasive procedures carry higher risk.
- All sources emphasize the importance of multimodal, multidisciplinary approaches and call for better-quality evidence and standardized outcome measures.

POLICY HISTORY

Date	Summary
December 2025	• Edited organization for clarity • Added Summary of Evidence and Analysis of Evidence per Medicare requirements • Updated citations • Removed indications for acute pancreatitis
December 2024	• This guideline replaces Evolent Clinical Guideline 404 Sympathetic Nerve Blocks • Removed indications for frostbite, embolism, vasospasm, hyperhidrosis, chronic nonsurgical neuropathic pain syndromes, nonsurgical vascular pain, and post-traumatic stress disorder

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Specialty Services Clinical Guideline Review Committee

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