2025 Evolent Clinical Guidelines for Medical Necessity Review - HMSA

INTERVENTIONAL PAIN MANAGEMENT GUIDELINES

Effective July 1, 2025 – June 30, 2026

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 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.

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.

See Legislative Language for specific mandates in the State of Washington

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 [2,3,4] related to the requested spinal region.

Treatment Purposes

- **Acute pain or exacerbation of chronic radicular pain (all of 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

- **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 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 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

These 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

LEGISLATIVE LANGUAGE

Washington

20160318B - Spinal Injections [7]

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. *ƒ*
- 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

Cervical Thoracic Region:

62320, 62321, 64479, +64480

Lumbar Sacral Region:

62322, 62323, 64483, +64484

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 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 components
  - Physical therapy
  - Physician-supervised home exercise program (HEP)**
  - Chiropractic care
- Inactive components
  - 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)

POLICY HISTORY

Date	Summary
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 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.

REFERENCES

1. Manchikanti L, Knezevic N, Navani A, Christo P, Limerick G et al. Epidural Interventions in the Management of Chronic Spinal Pain: American Society of Interventional Pain Physicians (ASIPP) Comprehensive Evidence-Based Guidelines. Pain Physician. Jan 2021; 24: S27-s208.

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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 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.
- 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

See Legislative Language for specific mandates in Washington

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:

- History of mainly axial pain or non-radicular pain unless stenosis is caused by synovial cyst (2)
- Lack of evidence that the primary source of pain being treated is from sacroiliac joint pain, discogenic pain, disc herniation, or radiculitis
- Chronic lumbar spondylolysis
  - Imaging studies confirming the presence of a pars interarticularis fracture/defect are required
- Pain causing functional disability or average pain level of ≥ 6 (scale of 0 to 10) related to the requested spinal region (3)
- Duration of pain for at least **3 months**
- 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

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

Imaging Guidance [4,5,6]

- The facet joint is commonly identified under image guidance by Computed tomography (CT) or Fluoroscopy. Medial Branch Blocks are commonly identified by Fluoroscopy. 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 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.

NOTE: ALL procedures must be performed under imaging guidance

Repeat Injections [1,7]

Facet joint injections and medial branch nerve blocks may be repeated only as **medically necessary**. **Each** injection requires an 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, provided at least 50% pain relief or significant documented functional improvement is obtained
    - If the most recent injection was a diagnostic block with local anesthetic only, there must be at least 7 days between injections
- If the first diagnostic injection is unsuccessful, 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) given there is a question about the pain generator or evidence of multi-level pathology

Therapeutic Phase

- Facet joint injections may only be repeated after the initial diagnostic 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 [8]
    - 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 allowable 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 neurolysis 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).

EXCLUSIONS

These requests are excluded from consideration under this guideline:

- 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 [3,5]

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

LEGISLATIVE LANGUAGE

Washington

20160318B – Spinal Injections [9]

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. ƒ
- 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

Cervical Thoracic Region:

64490, +64491, +64492, +0213T, +0214T, +0215T

Lumbar Region:

64493, +64494, +64495, 0216T, +0217T, +0218T

Applicable Lines of Business

☒	CHIP (Children's Health Insurance Program)
☒	Commercial

☒	Exchange/Marketplace
☒	Medicaid
☒	Medicare Advantage

BACKGROUND

Definitions [3,5]

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* [7]

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)** (10)

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 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"

Date	Summary
	● Included the full WA bill
January 2024	● Added Legislative Language for the State of Washington ● Added section on Image guidance ● Adjusted conservative treatment language in body and background sections ● Prolotherapy removed from the Exclusion section ● 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

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REFERENCES

1. Manchikanti L, Kaye A D, Soin A, Albers S L, Beall D et al. Comprehensive Evidence-Based Guidelines for Facet Joint Interventions in the Management of Chronic Spinal Pain: American Society of Interventional Pain Physicians (ASIPP) Guidelines. Pain physician. 2020; 23: S1-S127.

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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. 		
Original Date: October 2012	**Last Revised Date:** December 2024	**Implementation Date:** July 2025

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STATEMENT

General Information

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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

See Legislative Language for specific mandates in Washington

INDICATIONS FOR PARAVERTEBRAL FACET JOINT DENERVATION (RADIOFREQUENCY NEUROLYSIS)

Facet Joint Pain (1,2,3,4,5)

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

- Lack of evidence that the primary source of pain being treated is from sacroiliac joint pain, discogenic pain, disc herniation or radiculitis
- Pain causing functional disability or average pain level of ≥ 6 on a scale of 0 to 10 related to the requested spinal region
- Duration of pain of at least **3 months**
    - 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.
- Failure of **conservative treatment*** for a minimum of six (6) weeks in the last six (6) months
    - **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 the treatment (*Closure of medical or therapy offices, patient inconvenience, or noncompliance without explanation does not constitute 'inability to complete' treatment*)

Imaging Guidance [2,6]

- The facet joint is commonly identified under image guidance by Computed tomography (CT) or Fluoroscopy. Medial Branch Blocks are commonly identified by Fluoroscopy.

NOTE: All procedures must be performed using fluoroscopic or CT guidance

Repeat Procedures [2,3,6]

Facet joint denervation procedures may be repeated only as **medically necessary**. **Each** denervation procedure requires an 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 [4,5]

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

LEGISLATIVE LANGUAGE

Washington

20140321B – Facet Neurotomy [7]

Number and Coverage Topic:

20140321B – Facet Neurotomy

HTCC Coverage Determination:

Facet Neurotomy is a **covered benefit with conditions** consistent with the criteria identified in the reimbursement determination.

HTCC Reimbursement Determination:

Lumbar Facet Neurotomy is a **covered benefit with the following conditions**:

- Patient(s) must be over 17 years of age, and:
- Has at least six months of continuous low back pain referable to the facet joint
- The pain is non-radicular pain
- Condition is unresponsive to other therapies including conservative care
- There are no other clear structural cause of back pain
- There is no other pain syndrome affecting the spine.
- For identification, diagnosis, and treatment:
    - Patient must be selected by at least 80% improvement in pain after each of two differential medial branch blocks, one short-acting; one long-acting
    - One or two joints per each intervention, with documented, clinically significant improvement in pain and/or function for six months before further neurotomy at any level.

Cervical Facet Neurotomy for cervical pain is a **covered benefit with the following conditions**:

- Limited to C3 - 4, through C6 -7
- Patient(s) over 17 years of age, and:
- Has at least six months of continuous neck pain referable to the facet joint
- The pain is non-radicular
- Condition is unresponsive to other therapies including conservative care
- There are no other clear structural cause of neck pain
- No other pain syndrome affecting the spine
- For identification, diagnosis, and treatment:
    - Patient must be selected by 100% improvement in pain after each of two differential medial branch blocks, one short-acting, one long-acting
    - One joint per each intervention, with documented, clinically significant improvement in pain and/or function for six months before further neurotomy at any level.

Non-Covered Indicators

- Facet Neurotomy for the thoracic spine is **not covered**.
- Facet Neurotomy for headache is **not covered**.

CODING AND STANDARDS

Coding

CPT Codes

Cervical Thoracic Region:

64633, +64634

Lumbar Region:

64635, +64636

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 [3]:

- 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* [2,4]

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).

POLICY HISTORY

Date	Summary
December 2024	• This guideline replaces Evolent Clinical Guideline 302 for Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis) • Hyperlinked "conservative treatment" and "medical necessity" • Added Medical Necessity section for consistency with Paravertebral Facet Joint Injections or Blocks guideline
January 2024	• Added Legislative Language for the State of Washington • Added section on image guidance • Adjusted conservative treatment language in body and background sections • Reduced background • Added table of contents • Updated references

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Specialty Clinical Guideline Review Committee

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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

TABLE OF CONTENTS

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

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