Injections for Chronic Pain Conditions

Humana

Medicaid Medical Coverage Policy

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Table of Contents

Description

Injections for chronic pain conditions may be given for either diagnostic or therapeutic (treatment) purposes and may include epidural steroid injections, facet joint injections, regional sympathetic nerve blocks, sacroiliac joint injections, trigger point injections, dry needling of trigger points and/or peripheral nerve blocks. These injections are often included as part of a pain management program.

Epidural Steroid Injections

An epidural steroid injection (ESI) is used to help reduce radicular spinal pain that may be caused by pressure on a spinal nerve root as a result of a herniated disc, degenerative disc disease or spinal stenosis. This treatment is most frequently used for low back pain, though it may also be used for cervical (neck) or thoracic (midback) pain. An anesthetic medication, with or without a steroid (eg, corticosteroid, dexamethasone), is injected into the epidural space near the affected spinal nerve root with the assistance of computed tomography (CT) or fluoroscopy which allows the physician to view the placement of the needle. The goal of this treatment is to reduce inflammation and block the spinal nerve roots to relieve radicular pain or sciatica. It can also provide sufficient pain relief to allow the individual to progress with their rehabilitation program.

Approaches to the epidural space for the injection include:

- **Caudal** – The needle is placed near the coccyx (tailbone) into the sacral hiatus, allowing the treatment of pain which radiates into the lower extremities. This approach is commonly used to treat lumbar radiculopathy after prior surgery in the low back (post-laminectomy pain syndrome).

- **Interlaminar** – The needle is placed between the lamina of two vertebrae directly from the middle of the back. Medication is delivered to the nerve roots, via the epidural space, on both the right and left sides of the inflamed area at the same time.

- **Selective nerve root block (SNRB)** – The needle targets a specific nerve root, rather than the epidural space, delivering an anesthetic along the nerve itself. These injections generally should only be used for diagnostic purposes, often as part of surgical planning. While SNRBs are technically not an ESI, they are frequently discussed with them, and the terms may also erroneously be used interchangeably. They may also be referred to as diagnostic selective nerve root blocks (DSNRBs).

- **Transforaminal** – The needle is placed under radiographic guidance in such a way as to allow the medication to be directly applied onto the affected spinal nerve via the intervertebral foramen that lodges the nerve. This method treats one side at a time but, depending on the volume of the medication used, it may spread to one or multiple levels; it has been proposed to inject one or multiple levels during the same session, and either one or both sides. **(Refer to Coverage Limitations section, regarding multiple level injections)**

Facet Joint Injections

Facet injections, also known as facet blocks or medial branch blocks, are injections of a local anesthetic, with or without a steroid medication, into the facet joints or their nerve supply, the medial branch nerve.

Facet injections may be given for diagnostic purposes to determine if the facet joint is the source of pain[15] and must be performed under CT- or fluoroscopy-guidance. If the pain is relieved, the physician will know that the facet joint is likely to be the source of pain.

Regional Sympathetic Nerve Blocks

Regional sympathetic nerve blocks are performed by injecting a local anesthetic into the region of the relevant sympathetic ganglia, for the treatment of complex regional pain syndrome ([CRPS], previously known as reflex sympathetic dystrophy [RSD]). At the cervical level, these blocks may be referred to as stellate ganglion blocks and in the thoracic or lumbar level as paravertebral sympathetic blocks. As with other blocks, these may both aid in diagnosis of CRPS and be given as a therapeutic injection.

Sacroiliac Joint Injections

Sacroiliac (SI) joint injections are performed by injecting a local anesthetic, with or without a steroid medication, into the SI joints. These injections may be given for diagnostic purposes to determine if the SI joint is the source of the low back pain or may be performed to treat SI joint pain that has previously been diagnosed. If the pain is relieved, the physician will know that the SI joint appears to be the source of pain. This may be followed up with therapeutic injections of anti-inflammatory (steroid) and/or local anesthetic medications to relieve pain for longer periods.

Trigger Point Injections
Trigger point injections (TPI) are injections of a local anesthetic, with or without a steroid medication, into a painful area of a muscle that contains the trigger point. The purpose of a TPI is to relax the area of intense muscle spasm, effectively inactivate the trigger point and provide prompt symptomatic pain relief.

Dry Needling of Trigger Points
Dry needling differs from traditional acupuncture, even though it does make use of acupuncture-type needles. Acupuncture follows the principles of energy flow as a guide to where the needles will be inserted; in dry needling, needles are inserted directly into a myofascial trigger point, in an attempt to inactivate it, thereby theoretically decreasing the associated pain. Dry needling, though it targets a trigger point, differs from a trigger point injection, as there is no injection of medication or fluid. **(Refer to Coverage Limitations section)**

Peripheral Nerve Block
Peripheral nerve blocks consist of injection of a local anesthetic, with or without a steroid, into a peripheral nerve or a nerve ganglion, in an attempt to block pain signals and in theory provide prolonged relief from pain. Examples of peripheral nerve blocks include, but may not be limited to, cluneal nerve block, coccygeal nerve block, ganglion impar block, genicular nerve block, obturator nerve block or splanchnic nerve block. **(Refer to Coverage Limitations section)**

Other Therapeutic Injections
Injections may also be given into other structures in an attempt to alleviate chronic pain. Examples include, but may not be limited to, iliotibial (IT) band injection, intradiscal injection, pedicle screw block/hardware block of instrumentation used in spinal fusion or sacrococcygeal junction/sacrococcygeal ligament injection. **(Refer to Coverage Limitations section)**

Genicular artery embolization (GAE) is not an injection in the traditional sense of therapeutic injections (ie, not injecting a medication to block a nerve), but is used to treat knee pain as a result of osteoarthritis. It is theorized that inflammation in the synovium of the knee joint can lead to vascular endothelial cell proliferation, which promotes hyperplasia and knee vessel inflammation that can contribute to further joint tissue destruction, and may increase chronic pain by facilitating growth of sensory nerves along the newly formed vessels. In GAE, under x-ray imaging guidance, a catheter is advanced to the knee via the femoral artery, and an embolic agent is injected to block the blood flow in the genicular arteries and capillaries supplying the synovium. This purports to reduce inflammation and nerve growth, leading to decreased pain and potential delay of disease progression. **(Refer to Coverage Limitations section)**

Coverage Determination

NOTE: The scope of this policy is limited to CHRONIC pain management; it is NOT intended for use in consideration of acute postoperative pain control.

Epidural Steroid Injections
Humana members may be eligible under the Plan for **epidural steroid injections** via **caudal, interlaminar or transforaminal/SNRB approach** for back and neck pain when **ALL** of the following criteria are met:

- Failure to improve after 4 consecutive weeks of conservative treatment under the direction of a healthcare professional within the past 12 months, including **ALL** of the following:
    - Activity/lifestyle modification; **AND**
    - Medications (eg, nonsteroidal anti-inflammatory drugs [NSAIDs], non-narcotic analgesics) if medically appropriate and not contraindicated; **AND**
    - Physical therapy (PT), including a home exercise program (HEP); **AND**
- Pain is radicular in nature (radicular signs may include, but are not limited to, a positive straight leg raise or a dermatomal pattern of sensory loss); **AND**
- Maximum number of nerve root levels that may be performed in one session:
    - Caudal and interlaminar: injection at only 1 nerve root level per session, **AND** only 1 anatomical region per session **AND** not in conjunction with a transforaminal injection; **OR**
    - Transforaminal/SNRB: no more than 2 injections per session (a single nerve root level bilaterally or 2 nerve root levels unilaterally) **AND** only one anatomical region per session; **AND**
- Real-time imaging guidance (CT scan or fluoroscopy) must be used to assure proper needle placement (***this is considered integral to the primary procedure and not separately reimbursable***)

Diagnostic Phase:
- During the diagnostic phase, the individual may receive 2 injections at intervals of no sooner than 2 weeks; **AND**
- If diagnostic phase is completed and unsuccessful (less than a 50% reduction in pain and/or symptoms), no further injections are considered medically necessary

Therapeutic Phase:
- If the diagnostic phase is completed, the frequency of injections must be at least 2 months apart during the therapeutic phase, provided the individual has at least a 50% relief in pain and/or symptoms for 2 months; **AND**
- Total of 4 therapeutic epidural steroid injections per anatomical region per rolling 12 month period may be performed, only upon return of pain and/or deterioration in function **AND** only when responsiveness to prior injections has occurred (the individual should have at least a 50% reduction in pain and/or symptoms for 2 months)

Humana members may be eligible under the Plan for **epidural steroid injections (caudal, interlaminar, transforaminal)** for pain unresponsive to conservative measures *related to the following conditions* (a total of 6 injections per rolling 12 month period may be administered):

- Cancer (tumors or metastasis involving the spine); **OR**
- Complex regional pain syndrome (CRPS)/reflex sympathetic dystrophy (RSD); **OR**
- Herpes zoster/postherpetic neuralgia

Coverage Limitations

Epidural Steroid Injections

Humana members may **NOT** be eligible under the Plan for **epidural steroid injections (caudal, interlaminar, transforaminal/SNRB)** for any indications other than those listed above including, but may not be limited to:

- A preconceived treatment plan (eg, a series of 3 injections regardless of response to the prior injection); **OR**
- Epidural steroid injections performed at multiple nerve root levels (in excess of the maximum number outlined in the Coverage Determination section) OR at multiple anatomical regions during the same session (same date of service); **OR**
- Epidural steroid injections (regardless of the approach used) performed *without imaging guidance*; **OR**
- Epidural steroid injections via placement of an indwelling catheter for administration of a continuous infusion or intermittent bolus; **OR**
- Lumbar spinal stenosis *in the absence of radiculopathy*; **OR**
- Nonradicular pain (*unless* related to cancer, CRPS/RSD or herpes zoster/ postherpetic neuralgia); **OR**
- Repeat epidural injections when significant improvement has occurred after the initial injection or any subsequent injections. Repeat injections should *only* be performed upon return of pain and deterioration in the functional status; **OR**
- Therapeutic epidural injections in the absence of clinical improvements in pain and function after the initial 2 diagnostic injections; **OR**
- Use of real-time pressure-sensing guidance system (including, but may not be limited to Compuflo Epidural System); **OR**
- When other types of injections are performed on the same date of service, including, but not limited to, facet injections, sacroiliac joint injections, sympathetic blocks and/or trigger point injections. (Multiple injections on the same day could lead to an inaccurate or lack of diagnosis)

All other indications are considered not medically necessary.

Humana members may **NOT** be eligible under the Plan for the use of **ultrasound guidance for needle placement.** This is considered not medically necessary.

Humana members may **NOT** be eligible under the Plan for **monitored anesthesia care (MAC)** for epidural steroid injections. This is considered not medically necessary. Standard medical practice consists of local anesthesia and moderate sedation (99152, 99153).

Humana members may **NOT** be eligible under the Plan for **moderate sedation** administered by a provider (that is, a physician or CRNA) ***OTHER THAN*** the physician who is performing the diagnostic or therapeutic epidural steroid injection (99156, 99157). This is considered not medically necessary.

Note: These statements for moderate sedation, MAC or general anesthesia with pain management injections only apply to **ADULTS**. Moderate sedation (99151, 99152, 99153, 99155, 99156, 99157), MAC or general anesthesia with pain management injections may be medically necessary for an individual 17 years of age or younger.

Coverage Determination

Facet Joint Injections/Medial Branch Nerve Blocks
Humana members may be eligible under the Plan for ***diagnostic*** **facet joint injections** or **medial branch nerve blocks** for back or neck pain when facet joint syndrome is suspected, and **ALL** of the following criteria are met:

- *Absence* of nonfacet pathology per clinical assessment or radiology imaging that could explain the source of the pain (including, but may not be limited to, fracture, infection, significant spinal deformity or tumor); **AND**

- *Absence* of radiculopathy; **AND**

- Failure to improve after 6 consecutive weeks of conservative treatment under the direction of a healthcare professional within the past 12 months, including **ALL** of the following:

  - Activity/lifestyle modification; **AND**

  - Medications (eg, NSAIDs, non-narcotic analgesics) if medically appropriate and not contraindicated; **AND**

  - PT, including HEP; **AND**

- A second confirmatory injection is to be done IF the first injection was successful (at least 80% pain relief with the duration being consistent with the agent being used for the injection); the second injection should be no sooner than 3 weeks after the first, **AND** at the same level(s) as the initial injection; **AND**

- No more than 3 levels of facet joint injections per side, per anatomical region may be injected per session; **AND**

- Pain that is aggravated by extension, rotation or lateral bending of the spine and is not typically associated with neurological deficits; **AND**

- Real-time imaging guidance (CT scan or fluoroscopy) must be used to assure proper needle placement

Coverage Limitations

Facet Joint Injections, Medial Branch Nerve Blocks
Humana members may **NOT** be eligible under the Plan for **facet joint injections** or **medial branch nerve blocks** for any indications other than those listed above including, but may not be limited to:

- A preconceived treatment plan (eg, a series of 3 injections regardless of response to the prior injection); **OR**

- A second confirmatory/diagnostic injection if the first was not successful (at least 80% pain relief with the duration being consistent with the agent being used for the injection); **OR**

- Diagnostic facet joint injections/medial branch nerve blocks performed without a plan to perform radiofrequency ablation if the block were to be successful; **OR**

- Facet joint injections performed *without imaging guidance*; **OR**

- ***Therapeutic*** facet joint injections/medial branch blocks (for the TREATMENT of back or neck pain); **OR**

- When other types of injections are performed on the same date of service including, but not limited to, epidural steroid injections, sacroiliac joint injections, sympathetic blocks and/or trigger point injections. (Multiple injections on the same day could lead to an inaccurate or lack of diagnosis)

All other indications are considered not medically necessary.

Humana members may **NOT** be eligible under the Plan for the use of **ultrasound guidance for needle placement.** This is considered not medically necessary.

Humana members may **NOT** be eligible under the Plan for **monitored anesthesia care (MAC)** for facet joint injections or medial branch nerve blocks. This is considered not medically necessary. Standard medical practice consists of local anesthesia and moderate sedation (99152, 99153).

Humana members may **NOT** be eligible under the Plan for **moderate sedation** administered by a provider (that is, a physician or CRNA) *OTHER THAN* the physician who is performing the diagnostic facet joint injection or medal branch nerve blocks (99156, 99157). This is considered not medically necessary.

Note: These statements for moderate sedation, MAC or general anesthesia with pain management injections only apply to **ADULTS**. Moderate sedation (99151, 99152, 99153, 99155, 99156, 99157), MAC or

general anesthesia with pain management injections may be medically necessary for an individual 17 years of age or younger.

Coverage Determination

Regional Sympathetic Nerve Blocks
Humana members may be eligible under the Plan for **regional sympathetic nerve blocks** when the following criteria are met[27]:

- Diagnosis when sympathetically mediated CRPS is suspected as evidenced by **ALL** of the following criteria being met:
  - Continued, ongoing pain, disproportionate to any inciting event (eg, surgery, trauma); **AND**
  - **ONE** or more symptoms from **EACH** of the following categories:
    - Sensory: hyperesthesia, allodynia
    - Vasomotor: temperature asymmetry, skin color changes, skin color asymmetry
    - Sudomotor/edema: edema, sweating changes, sweating asymmetry
    - Motor/trophic: decreased range of motion (ROM), motor dysfunction (weakness, tremor, dystonia), trophic changes (hair, nails, skin); **AND**
  - **ONE** or more findings on physical exam in **TWO** or more of the following categories:
    - Sensory: evidence of hyperalgesia (to pinprick), allodynia (to light touch)
    - Vasomotor: evidence of temperature asymmetry, skin color changes, skin color asymmetry
    - Sudomotor/edema: evidence of edema, sweating changes, sweating asymmetry
    - Motor/trophic: evidence of decreased ROM, motor dysfunction (weakness, tremor, dystonia), trophic changes (hair, nails, skin); **AND**
- Real-time imaging guidance (CT scan or fluoroscopy) must be used to assure proper needle placement for either diagnostic or therapeutic injections; **AND**
- Utilization of these blocks is to be with the intent to allow participation in an active rehabilitation program

Diagnostic Phase:
- A diagnostic block is performed to confirm (or disprove) the presence of sympathetically mediated CRPS; **AND**

- A second diagnostic block may be performed if the initial block was successful (a 50% reduction in pain and improved function) and if performed within the first 2 weeks of the initial block; **AND**

- If the diagnostic phase is completed and unsuccessful (less than 50% pain relief and no improvement in function), no further injections will be covered

Therapeutic Phase:

- If the diagnostic phase is completed and successful (at least a 50% reduction in pain and improvement in function), therapeutic injections may be initiated; **AND**

- Up to a maximum of 6 total blocks may be performed at a frequency of no more than one per week (per rolling 12 month period):

AND all of the following:

  - A 50% reduction in pain is achieved; **AND**

  - Decrease in pain medication use; **AND**

  - Improved/increased functional ability (increased ROM, strength and use of the extremity in activities of daily living [ADLs], increased tolerance to touch); **AND**

  - Ongoing participation in an active rehabilitation program

Coverage Limitations

Regional Sympathetic Nerve Blocks

Humana members may **NOT** be eligible under the Plan for **regional sympathetic nerve blocks** for any indications other than those listed above including, but may not be limited to:

- Diagnostic block was not successful (less than 50% reduction in pain); **OR**

- Individual is not capable of or willing to participate in an ongoing, active rehabilitation program; **OR**

- Regional sympathetic nerve blocks performed *without* imaging guidance; **OR**

- Repeat therapeutic block when there has not been any decrease in pain medication use, increased function/participation in ADLs or increased tolerance to touch; **OR**

- When other types of injections are performed on the same date of service including, but not limited to, epidural steroid injections, facet joint blocks/medial branch nerve blocks, sacroiliac joint injections and/or trigger point injections. (Multiple injections on the same day could lead to an inaccurate or lack of diagnosis)

All other indications are considered not medically.

Humana members may **NOT** be eligible under the Plan for the use of **ultrasound guidance for needle placement.** This is considered not medically necessary.

Humana members may **NOT** be eligible under the Plan for **monitored anesthesia care (MAC)** for regional sympathetic nerve blocks. This is considered not medically necessary. Standard medical practice consists of local anesthesia and moderate sedation (99152, 99153).

Humana members may **NOT** be eligible under the Plan for **moderate sedation** administered by a provider (that is, a physician or CRNA) *OTHER THAN* the physician who is performing the diagnostic or therapeutic regional sympathetic nerve blocks (99156, 99157). This is considered not medically necessary.

Note: These statements for moderate sedation, MAC or general anesthesia with pain management injections only apply to **ADULTS**. Moderate sedation (99151, 99152, 99153, 99155, 99156, 99157), MAC or general anesthesia with pain management injections may be medically necessary for an individual 17 years of age or younger.

Coverage Determination

Sacroiliac Joint Injections
Humana members may be eligible under the Plan for **intra-articular sacroiliac joint injections** when the following criteria are met:

- Chronic low back pain when the sacroiliac joint is suspected to be the source of pain; **AND**
- Failure to improve after 12 consecutive weeks of conservative treatment under the direction of a healthcare professional within the past 12 months, including **ALL** of the following:
    - Activity/lifestyle modification; **AND**
    - Medications (eg, NSAIDs, non-narcotic analgesics) if medically appropriate and not contraindicated; **AND**
    - PT, including HEP; **AND**
- Positive response (reproduction of individual's typical SIJ pain) to at least 2 of the following provocative tests/maneuvers:
    - Compression test
    - Distraction test
    - FABER test (also referred to as Patrick test)
    - Gaenslen's test
    - Thigh thrust test (also referred to as posterior pelvic pain provocation; **AND**

- Sacroiliac joint injections are to be performed with imaging guidance (CT scan or fluoroscopy) to assure correct needle placement

Diagnostic Phase:

- During the diagnostic phase, an individual may receive 2 injections at intervals of no sooner than 2 weeks; **AND**

- If injections are to be done for different joints (left versus right) they are to be done at intervals of no sooner than one week apart (though it is recommended that both joints be injected at the same time); **AND**

- If the diagnostic phase is completed and unsuccessful (less than an 75% reduction in pain and/or symptoms), no further injections will be covered

Therapeutic Phase:

- The previous SIJ injection produced at least consistent 50% pain relief **or** at least 50% consistent improvement in the ability to perform previously painful movements and activities of daily living (ADLs) for at least 3 months from the proximate therapeutic SIJ injection procedure and compared to baseline measurements for ADLs and painful movements or pain relief using the same pain scale; **AND**

- If injections are to be done for different joints (left versus right), and the above criteria are met, the frequency is to remain at least 3 months between injections (though it is recommended that both sides be treated at the same time, rather than one at a time); **AND**

- Total of 4 therapeutic injections (per joint per rolling 12 month period) may be performed only upon return of pain and/or deterioration in function and only when responsiveness to prior injections has occurred (the individual should have at least an 50% reduction in pain and/or symptoms for 3 months)

Coverage Limitations

Sacroiliac Joint Injections

Humana members may **NOT** be eligible under the Plan for **sacroiliac joint injections** for any indications other than those listed above including, but not limited to:

- Lateral branch nerve blocks to the SI joint for diagnostic or therapeutic purposes **OR** for diagnostic purposes prior to a neuroablative procedure to the SI joint; **OR**

- Repeat SI joint injections in the absence of clinical improvement in pain and function after the initial 2 diagnostic injections; **OR**

- Repeat SI joint injections when significant improvement has occurred after the initial injection or any subsequent injections. Repeat injections should *only* be performed upon return of pain and deterioration in the functional status; **OR**

- SI joint injections performed *without imaging guidance*; **OR**

- When other types of injections are performed on the same date of service including, but not limited to, epidural steroid injections, facet injections, sympathetic blocks and/or trigger point injections. (Multiple injections on the same day could lead to an inaccurate or lack of diagnosis)

All other indications are considered not medically necessary.

Humana members may **NOT** be eligible under the Plan for the use of **ultrasound guidance for needle placement.** This is considered not medically necessary.

Humana members may **NOT** be eligible under the Plan for **monitored anesthesia care (MAC)** for sacroiliac joint injections. This is considered not medically necessary. Standard medical practice consists of local anesthesia and moderate sedation (99152, 99153).

Humana members may **NOT** be eligible under the Plan for **moderate sedation** administered by a provider (that is, a physician or CRNA) *OTHER THAN* the physician who is performing the diagnostic or therapeutic sacroiliac joint injection (99156, 99157). This is considered not medically necessary.

Note: These statements for moderate sedation, MAC or general anesthesia with pain management injections only apply to **ADULTS**. Moderate sedation (99151, 99152, 99153, 99155, 99156, 99157), MAC or general anesthesia with pain management injections may be medically necessary for an individual 17 years of age or younger.

Coverage Determination

Trigger Point Injections
Humana members may be eligible under the Plan for **trigger point injections** for the treatment of myofascial pain syndrome when the following criteria are met:

- Presence of symptomatic palpable trigger point(s); **AND**

- Failure to improve after 12 consecutive weeks of conservative treatment under the direction of a healthcare professional within the past 12 months, including **ALL** of the following:

  - Activity/lifestyle modification; **AND**

  - Medications (eg, NSAIDs, non-narcotic analgesics) if medically appropriate and not contraindicated; **AND**

  - PT, including HEP; **AND**

Diagnostic (Stabilization) Phase:
- During the diagnostic (stabilization) phase, an individual may receive injections at intervals of no sooner than 1 week; **AND**

- Up to 4 sets of injections may be necessary to diagnose the source of the individual's pain and achieve a therapeutic effect; **AND**

- If diagnostic (stabilization) phase is completed and unsuccessful (less than a 50% reduction in pain and/or symptoms), no further injections are covered

Therapeutic Phase:
- If the diagnostic (stabilization) phase is completed, the frequency of injections must be at least 2 months apart during the therapeutic phase, provided the individual has at least a 50% relief in pain and/or symptoms for 6 weeks; **AND**

- Total of 6 sessions of therapeutic trigger point injections per rolling 12 month period may be performed only upon return of pain and/or deterioration in function AND only when responsiveness to prior injections has occurred (the individual should have at least a 50% reduction in pain and/or symptoms for 6 weeks)

Coverage Limitations

Trigger Point Injections
Humana members may **NOT** be eligible under the Plan for **trigger point injections** for any indications other than those listed above including, but not limited to:

- Repeat therapeutic trigger point injections in the absence of clinical improvement in pain and function after the initial diagnostic injections; **OR**

- Repeat trigger point injections when significant improvement has occurred after the initial injection or any subsequent injections. Repeat injections should *only* be performed upon return of pain and deterioration in the functional status; **OR**

- When other types of injections are performed on the same date of service including, but not limited to, epidural steroid injections, facet injections, sacroiliac joint injections and/or sympathetic blocks (Multiple injections on the same day could lead to an inaccurate or lack of diagnosis)

All other indications are considered not medically necessary.

Humana members may **NOT** be eligible under the Plan for **dry needling of trigger points** (needle insertion without injection). This is considered experimental/investigational as it is not identified as widely used and generally accepted for the proposed use as reported in nationally recognized peer-reviewed medical literature published in the English language.

Humana members may **NOT** be eligible under the Plan for the use of **ultrasound guidance for needle placement.** This is considered not medically necessary.

Humana members may **NOT** be eligible under the Plan for **monitored anesthesia care (MAC)** for trigger point injections. This is considered not medically necessary. Standard medical practice consists of local anesthesia and moderate sedation (99152, 99153).

Humana members may **NOT** be eligible under the Plan for **moderate sedation** administered by a provider (that is, a physician or CRNA) *OTHER THAN* the physician who is performing the diagnostic or therapeutic trigger point injection (99156, 99157). This is considered not medically necessary.

Note: These statements for moderate sedation, MAC or general anesthesia with pain management injections only apply to **ADULTS**. Moderate sedation (99151, 99152, 99153, 99155, 99156, 99157), MAC or general anesthesia with pain management injections may be medically necessary for an individual 17 years of age or younger.

Coverage Limitations

Other Miscellaneous Injections for Pain Conditions
Humana members may **NOT** be eligible under the Plan for the following injections for any indication, including for management/treatment of chronic pain:

- Cluneal nerve block; **OR**
- Coccygeal nerve block; **OR**
- Ganglion impar block; **OR**
- Genicular artery embolization; **OR**
- Genicular nerve block; **OR**
- Iliotibial (IT) band injection; **OR**
- Intradiscal injection with **ANY** substance (eg, allogenic cellular product, allogenic tissue-based product, mesenchymal stem cells, methylene blue, notochordal cell-derived matrix, oxygen/ozone, platelet rich plasma [PRP], steroids, tumor necrosis factor [TNF] alpha, VIA disc allograft [may also be referred to as VIA disc matrix]); **OR**
- Obturator nerve block; **OR**
- Paravertebral block for chronic pain (paravertebral blocks *may* be appropriate when used for immediate postoperative pain management, for specific surgical procedures, however, this indication is outside of the scope of this Medical Coverage Policy); **OR**
- Pedicle screw block/hardware block of instrumentation used in spinal fusions; **OR**

- Pudendal nerve block; **OR**
- Repetitive peripheral nerve blocks for chronic nonmalignant pain; **OR**
- Sacrococcygeal junction/sacrococcygeal ligament injection (for any indication, including coccydynia); **OR**
- Splanchnic nerve block

These are considered experimental/investigational as they are not identified as widely used and generally accepted for the proposed uses as reported in nationally recognized peer-reviewed medical literature published in the English language.

Humana members may **NOT** be eligible under the Plan for **moderate sedation, monitored anesthesia care (MAC) or general anesthesia** provided for any injections listed in this section (and including, but may not be limited to, peripheral joint injections [eg, hip or knee]) related to pain management procedures. These are considered not medically necessary.

Note: This statement for moderate sedation, MAC or general anesthesia with pain management injections only applies to **ADULTS**. Moderate sedation (99151, 99152, 99153, 99155, 99156, 99157), MAC or general anesthesia with pain management injections may be medically necessary for an individual 17 years of age or younger.

Coding Information

Any codes listed on this policy are for informational purposes only. Do not rely on the accuracy and inclusion of specific codes. Inclusion of a code does not guarantee coverage and/or reimbursement for a service or procedure.

CPT® Code(s)	Description	Comments
01991	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different physician or other qualified health care professional); other than the prone position	
01992	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different physician or other qualified health care professional); prone position	
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	

20551	Injection(s); single tendon origin/insertion	
20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)	
20553	Injection(s); single or multiple trigger point(s), 3 or more muscles	
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	
20561	Needle insertion(s) without injection(s); 3 or more muscles	
20605	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance	
20999	Unlisted procedure, musculoskeletal system, general	
22899	Unlisted procedure, spine	
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed	
62320	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance	
62321	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	
62322	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance	

62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	
64430	Injection(s), anesthetic agent(s) and/or steroid; pudendal nerve	
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	
64454	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed	
64461	Paravertebral block (PVB) (paraspinous block), thoracic; single injection site (includes imaging guidance, when performed)	
64462	Paravertebral block (PVB) (paraspinous block), thoracic; second and any additional injection site(s) (includes imaging guidance, when performed) (List separately in addition to code for primary procedure)	
64463	Paravertebral block (PVB) (paraspinous block), thoracic; continuous infusion by catheter (includes imaging guidance, when performed)	
64479	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level	
64480	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, each additional level (List separately in addition to code for primary procedure)	
64483	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level	

64484	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)	
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 level(s) (List separately in addition to code for primary procedure)	
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level	
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)	
64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)	
64510	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)	
64520	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)	
64640	Destruction by neurolytic agent; other peripheral nerve or branch	

64680	Destruction by neurolytic agent, with or without radiologic monitoring; celiac plexus	
64999	Unlisted procedure, nervous system	
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	
77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)	
77012	Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation	
99151	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age	
99152	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older	
99153	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	

99155	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age	
99156	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older	
99157	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	
CPT® Category III Code(s)	**Description**	**Comments**
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)	
0215T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)	
0216T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; single level	
0217T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; second level (List separately in addition to code for primary procedure)	

0218T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)	
0627T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; first level	
0628T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; each additional level (List separately in addition to code for primary procedure)	
0629T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; first level	
0630T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; each additional level (List separately in addition to code for primary procedure)	
0777 T	Real-time pressure-sensing epidural guidance system (List separately in addition to code for primary procedure)	
HCPCS Code(s)	**Description**	**Comments**
G0260	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography	

References

1. Abram S. Treatment of lumbosacral radiculopathy with epidural steroids. *Anesthesiology.* 1999;91:1937-1941.

2. Agency for Healthcare Research and Quality (AHRQ). Comparative Effectiveness Review. Interventional treatments for acute and chronic pain: systematic review. https://www.ahrq.gov. Published September 2021.

3. Agency for Healthcare Research and Quality (AHRQ). Technology Assessment (ARCHIVED). Pain management injection therapies for low back pain. https://www.ahrq.gov. Published March 20, 2015. Updated July 10, 2015.

4. Alvarez D, Rockwell, P. Trigger points: diagnosis and management. *American Family Physician.* 2002;65(4):653-660.

5. American Academy of Neurology. Assessment: use of epidural steroid injections to treat lumbosacral pain. https://www.neurology.org. Published March 6, 2007. Updated April 30, 2022.

6. American Academy of Orthopedic Surgeons (AAOS). Evidence-Based Guideline. 3rd edition. Treatment of osteoarthritis of the knee. https://www.aaos.org. Published August 31, 2021.

7. American Academy of Orthopaedic Surgeons (AAOS). Ortho Info. Cervical radiculopathy (pinched nerve). https://www.aaos.org. Published February 2010. Updated June 2024.

8. American Society of Anesthesiologists (ASA). Statement on anesthetic care during interventional pain procedures for adults. https://www.asahq.org. Published October 22, 2005. Updated October 13, 2021.

9. American Society of Anesthesiologists (ASA). Statement on continuum of depth of sedation: definition of general anesthesia and levels of sedation/analgesia. https://www.asahq.org. Published October 13, 1999. Updated October 23, 2019.

10. American Society of Anesthesiologists (ASA). Statement on distinguishing monitored anesthesia care ("MAC") from moderate sedation/analgesia (conscious sedation). https://www.asahq.org. Published October 18, 2023.

11. American Society of Anesthesiologists (ASA). Statement on the medical necessity of anesthesiology services. https://www.asahq.org. Published October 16, 2013. Updated October 18, 2023.

12. American Society of Interventional Pain Physicians (ASIPP). American Society of Interventional Pain Physicians (ASIPP) Comprehensive Evidence-Based Guidelines. Epidural interventions in the management of chronic spinal pain. https://www.asipp.org. Published January 2021.

13. American Society of Interventional Pain Physicians (ASIPP). American Society of Interventional Pain Physicians (ASIPP) Guidelines. Comprehensive evidence-based guidelines for facet joint interventions in the management of chronic spinal pain. https://www.asipp.org. Published June 2020.

14. American Society of Interventional Pain Physicians (ASIPP). American Society of Interventional Pain Physicians (ASIPP) Guidelines. Responsible, safe, and effective use of biologics in the management of low back pain. https://www.asipp.org. Published 2019.

15. American Society of Interventional Pain Physicians (ASIPP). An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations. https://www.asipp.org. Published 2013.

16. American Society of Interventional Pain Physicians (ASIPP). ASIPP guidelines for sedation and fasting status of patients undergoing interventional pain management procedures. https://www.asipp.org. Published 2019.

17. American Society of Pain and Neuroscience (ASPN). Evidence-based clinical guideline of interventional treatments for low back pain. https://www.aspnpain.com. Published December 2022.

18. American Society of Regional Anesthesia and Pain Medicine (ASRA). Complex regional pain syndrome. https://www.asra.com. Published August 6, 2019.

19. American Society of Regional Anesthesia and Pain Medicine (ASRA). Consensus practice guidelines on interventions for cervical spine (facet) joint from a multispecialty international working group. https://www.asra.com. Published December 8, 2021.

20. American Society of Regional Anesthesia and Pain Medicine (ASRA). Consensus practice guidelines on interventions for lumbar facet joint pain from a multispecialty international working group. https://www.asra.com. Published October 12, 2020.

21. American Society of Regional Anesthesia and Pain Medicine (ASRA). Myofascial pain and fibromyalgia syndrome. https://www.asra.com. Published August 6, 2019.

22. American Society of Regional Anesthesia and Pain Medicine (ASRA). Sacroiliac joint injections, lateral branch blocks. https://www.asra.com. Published August 6, 2019.

23. Benyamin RM, Manchikanti L, Parr AT, et al. The effectiveness of lumbar interlaminar epidural injections in managing chronic low back and lower extremity pain. *Pain Physician*. 2012;15:E363-404.

24. Chou R, Hashimoto R, Friedly J, et al. Epidural corticosteroid injections for radiculopathy and spinal stenosis. *Ann Intern Med.* 2015;163(5):373-396.

25. Chou R, Loeser J, Owens D, et al. Interventional therapies, surgery, and interdisciplinary rehabilitation for low back pain - an evidence-based clinical practice guideline from the American Pain Society. *Spine*. 2009;34:1066-1077.

26. ClinicalKey. Waldman S. Genicular nerve block. In: Waldman S. *Atlas of Pain Management Injection Techniques.* 5th ed. Elsevier; 2023:785-793. https://www.clinicalkey.com.

27. ClinicalKey. Williams K, Guarino A, Raja S. Complex regional pain syndrome. In: Benzon H. *Essentials of Pain Medicine.* Elsevier; 2018:223-232.e2. https://www.clinicalkey.com.

28. Cohen S, White R, Kurihara C, et al. Epidural steroids, etanercept or saline in subacute sciatica. A multicenter randomized trial. *Ann Intern Med.* 2012;156:551-559.

29. Cohen SP, Bicket MC, Jamison D, Wilkinson I, Rathmell JP. Epidural steroids: a comprehensive, evidence-based review. *Reg Anesth Pain Med*. 2013;38:175-200.

30. Cohen SP, Raja SN. Pathogenesis, diagnosis, and treatment of lumbar zygapophysial (facet) joint pain. *Anesthesiology*. 2007;106(3):591-614.

31. Congress of Neurological Surgeons (CNS). Guideline update for the performance of fusion procedures for degenerative disease of the lumbar spine. Part 13: injection therapies, low back pain, and lumbar fusion. https://www.cns.org. Published 2006. Updated July 2014.

32. Datta S, Manchikanti L, Falco F, et al. Diagnostic utility of selective nerve root blocks in the diagnosis of lumbosacral radicular pain: systematic review and update of current evidence. *Pain Physician.* 2013;16:SE97-SE124.

33. Derby R, Melnik I, Choi J, Lee J. Indications for repeat diagnostic medial branch nerve blocks following a failed first medial branch nerve block. *Pain Physician.* 2013;16:479-488.

34. ECRI Institute. Clinical Evidence Analysis. VIA Disc Allograft (Vivex Biologics, Inc.) for treating lumbar degenerative disc disease. https://www.ecri.org. Published June 28, 2021.

35. ECRI Institute. Hotline Response (ARCHIVED). Monitored anesthesia care during interventional pain management procedures. https://www.ecri.org. Published July 15, 2016.

36. Friedly J, Comstock B, Turner J, et al. A randomized trial of epidural glucocorticoid injections for spinal stenosis. *N Engl J Med.* 2014;371:11-21.

37. Ghahreman A, Ferch R, Bogduk N. The efficacy of transforaminal injection of steroids for the treatment of lumbar radicular pain. *Pain Med.* 2010;11:1149-1168.

38. Gharibo C, Varlotta G, Rhame E, Liu E, Bendo J, Perloff M. Interlaminar versus transforaminal epidural steroids for the treatment of subacute lumbar radicular pain: a randomized, blinded, prospective outcome study. *Pain Physician.* 2011;14:499-511.

39. Hayes, Inc. Emerging Technology Report. Genicular artery embolization with Embozene Microspheres (Varian, a Siemens Healthineers Company) for symptomatic knee osteoarthritis. https://evidence.hayesinc.com. Published October 19, 2023.

40. Hayes, Inc. Emerging Technology Report. Rebonuputemcel injectable discogenic cell therapy (IDCT; DiscGenics Inc.) for degenerative disc disease. https://evidence.hayesinc.com. Published November 15, 2023.

41. Hayes, Inc. Evidence Analysis Research Brief. Cluneal nerve block for treatment of low back pain. https://evidence.hayesinc.com. Published September 23, 2021.

42. Hayes, Inc. Evidence Analysis Research Brief. CompuFlo Epidural System (Milestone Scientific Inc.) for identification of the epidural space. https://evidence.hayesinc.com. Published March 14, 2024.

43. Hayes, Inc. Evidence Analysis Research Brief. Dry needling for pelvic floor muscle dysfunction or pain. https://evidence.hayesinc.com. Published June 23, 2021.

44. Hayes, Inc. Evidence Analysis Research Brief. Dry needling of painful myofascial trigger points in adults. https://evidence.hayesinc.com. Published November 15, 2022.

45. Hayes, Inc. Evidence Analysis Research Brief. Genicular artery embolization for treatment of knee osteoarthritis. https://evidence.hayesinc.com. Published August 28, 2023.

46. Hayes, Inc. Evidence Analysis Research Brief. Nerve blockade for treatment of chronic shoulder pain. https://evidence.hayesinc.com. Published April 7, 2023.

47. Hayes, Inc. Evidence Analysis Research Brief. Nerve blockade of the articular branches of the femoral and obturator nerves for treatment of hip arthritis. https://evidence.hayesinc.com. Published March 20, 2023.

48. Hayes, Inc. Evidence Analysis Research Brief. Sacroiliac joint injections with corticosteroids for treatment of chronic low back pain. https://evidence.hayesinc.com. Published April 18, 2022.

49. Hayes, Inc. Evolving Evidence Review. Epidural steroid injections for the treatment of thoracic spine pain. https://evidence.hayesinc.com. Published July 23, 2021. Updated March 16, 2023.

50. Hayes, Inc. Evolving Evidence Review. Middle cluneal nerve block for treatment of low back pain. https://evidence.hayesinc.com. Published January 4, 2022. Updated March 13, 2024.

51. Hayes, Inc. Evolving Evidence Review. Superior cluneal nerve block for treatment of low back pain. https://evidence.hayesinc.com. Published December 30, 2021. Updated January 16, 2024.

52. Hayes, Inc. Evolving Evidence Review. Via Disc NP (Vivex Biologics Inc.) for relief of intervertebral disc degeneration symptoms. https://evidence.hayesinc.com. Published August 4, 2022. Updated July 28, 2023.

53. Hayes, Inc. Health Technology Assessment. Dry needling for knee osteoarthritis in adults. https://evidence.hayesinc.com. Published June 29, 2023. Updated June 18, 2024.

54. Hayes, Inc. Health Technology Assessment. Dry needling for mechanical neck and/or trapezius muscle pain in adults. https://evidence.hayesinc.com. Published May 18, 2023. Updated May 13, 2024.

55. Hayes, Inc. Health Technology Assessment. Ganglion impar block or radiofrequency thermocoagulation for treatment of chronic coccydynia. https://evidence.hayesinc.com. Published July 21, 2022. Updated July 26, 2023.

56. Hayes, Inc. Health Technology Assessment. Genicular nerve block for treatment of knee osteoarthritis. https://evidence.hayesinc.com. Published December 7, 2023.

57. Hayes, Inc. Health Technology Assessment. Sacroiliac joint injection with corticosteroids for treatment of sacroiliac joint and low back pain. https://evidence.hayesinc.com. Published June 13, 2023. Updated July 1, 2024.

58. Hayes, Inc. Health Technology Brief. Epidural injection of Enbrel (etanercept; Immunex Corp.) for treatment of low back pain due to lumbar disc disease. https://evidence.hayesinc.com. Published December 23, 2013. Updated December 9, 2015.

59. Hayes, Inc. Health Technology Brief. Pudendal nerve block for treatment of pudendal neuralgia. https://evidence.hayesinc.com. Published June 22, 2013. Updated May 19, 2015.

60. Hayes, Inc. Medical Technology Directory. Comparative effectiveness review of paravertebral block for prevention of chronic pain after breast surgery. https://evidence.hayesinc.com. Published August 3, 2017. Updated September 16, 2021.

61. Hayes, Inc. Medical Technology Directory. Epidural steroid injections for cervical radiculopathy. https://evidence.hayesinc.com. Published February 28, 2019. Updated February 3, 2022.

62. Hayes, Inc. Medical Technology Directory. Epidural steroid injections for low back pain and sciatica. https://evidence.hayesinc.com. Published January 30, 2013. Updated January 6, 2017.

63. Hayes, Inc. Medical Technology Directory. Intra-articular facet joint injections for the treatment of chronic nonmalignant spinal pain of facet joint origin. https://evidence.hayesinc.com. Published April 19, 2018. Updated April 6, 2022.

64. Hayes, Inc. Medical Technology Directory. Medial branch nerve block injections for the treatment of chronic nonmalignant spinal pain of facet joint origin. https://evidence.hayesinc.com. Published January 18, 2018. Updated January 21, 2022.

65. Hayes, Inc. Medical Technology Directory. Trigger point injections for myofascial pain. https://evidence.hayesinc.com. Published December 24, 2013. Updated December 19, 2017.

66. Kastler A, Aubry S, Piccand V, Hadjidekov G, Tiberghien F, Kastler B. Radiofrequency neurolysis versus local nerve infiltration in 42 patients with refractory chronic inguinal neuralgia. *Pain Physician.* 2012;15:237-244.

67. Kennedy D, Zheng P, Smuck M, McCormick Z, Huynh L, Schneider B. A minimum of 5-year follow-up after lumbar transforaminal epidural steroid injections in patients with lumbar radicular pain due to intervertebral disc herniation. *Spine J.* 2018;18:29-35.

68. Kim E, Chotai S, Stonko D, et al. Patient-reported outcomes after lumbar epidural steroid injection for degenerative spine disease in depressed versus non-depressed patients. *Spine J.* 2017;17:511-517.

69. Koltsov J, Smuck M, Zagel A, et al. Lumbar epidural steroid injections for herniation and stenosis: incidence and risk factors of subsequent surgery. *Spine J.* 2019;19:199-205.

70. Lavelle E, Lavelle W, Smith H. Myofascial trigger points. *Med Clin No Am*. 2007;91(2):229-239.

71. Lewandrowski K-U, Dowling A, Vera J, Leon J, Telfeian A, Lorio M. Pain relief after allogenic stem cell disc therapy. *Pain Physician.* 2023;26:197-206. https://www.painphysicianjournal.com.

72. MacVicar, J, King, W, Landers, MH, Bogduk, N. The effectiveness of lumbar transforaminal injection of steroids: a comprehensive review with systematic analysis of the published data. *Pain Medicine*. 2013;14(1):14-28.

73. Manchikanti L. Transforaminal lumbar epidural steroid injections. *Pain Physician.* 2000;3(4):374-398.

74. Manchikanti L, Cash K, McManus C, Pampati V, Benyamin RM. Fluoroscopic lumbar interlaminar epidural injections in managing chronic lumbar axial or discogenic pain. *J Pain Res.* 2012;5:301-311.

75. Manchikanti L, Cash K, McManus C, Pampati V, Fellows B. Results of 2-year follow-up of a randomized, double-blind, controlled trial of fluoroscopic caudal epidural injections in central spinal stenosis. *Pain Physician.* 2012;15:371-384.

76. Manchikanti L, Cash K, Pampati V, Wargo B, Malla Y. A randomized, double-blind active control trial of fluoroscopic cervical interlaminar epidural injections in chronic pain of cervical disc herniation: results of a 2-year follow-up. *Pain Physician.* 2013;16:465-478.

77. Manchikanti L, Knezevic E, Knezevic N, et al. Effectiveness of facet joint nerve blocks in managing chronic axial spinal pain of facet joint origin: a systematic review and meta-analysis. *Pain Physician.* 2024;27:E169-E206.

78. Manchikanti L, Malla Y, Wargo B, Cash K, Pampati V, Fellows B. A prospective evaluation of complications of 10,000 fluoroscopically directed epidural injections. *Pain Physician.* 2012;15:131-140.

79. Manchikanti L, Nampiaparampil D, Candido K, et al. Do cervical epidural injections provide long-term relief in neck and upper extremity pain? A systematic review. *Pain Physician.* 2015;18:39-60.

80. Manchikanti L, Singh V, Cash K, Pampati V, Damron K, Boswell M. Effect of fluoroscopically guided caudal epidural steroid or local anesthetic injections in the treatment of lumbar disc herniation and radiculitis: a randomized, controlled, double blind trial with a two-year follow-up. *Pain Physician.* 2012;15:273-286.

81. Manchikanti L, Singh V, Cash K, Pampati V, Datta S. Management of pain of post lumbar surgery syndrome: one-year results of a randomized, double-blind, active controlled trial of fluoroscopic caudal epidural injections. *Pain Physician*. 2010;13:509-521.

82. Manchikanti L, Singh V, Cash K, Pampati V, Falco F. A randomized, double-blind, active-control trial of the effectiveness of lumbar interlaminar epidural injections in disc herniation. *Pain Physician*. 2014;17:E61-E74.

83. Manchikanti L, Singh V, Kloth D, et al. Interventional techniques in the management of chronic pain: part 2.0. American Society of Interventional Pain Physicians (ASIPP) practice guidelines. *Pain Physician*. 2001;4(1):24-98.

84. Navani A, Ambach M, Calodney A, et al. The safety and effectiveness of orthobiologic injections for discogenic chronic low back pain: a multicenter prospective, crossover, randomized controlled trial with 12 months follow-up. *Pain Physician.* 2024;27:E65-E77.

85. Nguyen C, Boutron I, Baron G, et al. Intradiscal glucocorticoid injection for patients with chronic low back pain associated with active discopathy. *Ann Intern Med*. 2017;166(8):547-556.

86. North American Spine Society (NASS). Coverage Policy Recommendations. Epidural steroid injections and selective spinal nerve blocks. https://www.spine.org. Published February 2020.

87. North American Spine Society (NASS). Coverage Policy Recommendations. Facet joint interventions. https://www.spine.org. Published October 2016.

88. North American Spine Society (NASS). Coverage Policy Recommendations. Sacroiliac joint injections and radiofrequency ablation. https://www.spine.org. Published October 2020.

89. North American Spine Society (NASS). Evidence-Based Clinical Guidelines for Multidisciplinary Spine Care. Diagnosis and treatment of cervical radiculopathy from degenerative disorders. https://www.spine.org. Published 2010.

90. North American Spine Society (NASS). Evidence-Based Clinical Guidelines for Multidisciplinary Spine Care. Diagnosis and treatment of degenerative lumbar spinal stenosis. https://www.spine.org. Published 2007. Updated 2011.

91. North American Spine Society (NASS). Evidence-Based Clinical Guidelines for Multidisciplinary Spine Care. Diagnosis and treatment of degenerative lumbar spondylolisthesis. https://www.spine.org. Published 2008. Updated 2014.

92. North American Spine Society (NASS). Evidence-Based Clinical Guidelines for Multidisciplinary Spine Care. Diagnosis and treatment of low back pain. https://www.spine.org. Published 2020.

93. North American Spine Society (NASS). Evidence-Based Clinical Guidelines for Multidisciplinary Spine Care. Diagnosis and treatment of lumbar disc herniation with radiculopathy. https://www.spine.org. Published 2012.

94. Novak S, Nemeth W. The basis for recommending repeating epidural steroid injections for radicular low back pain: a literature review. *Arch Phys Med Rehabil.* 2008;89:543-552.

95. Pinto R, Maher C, Ferreira M, et al. Epidural corticosteroid injections in the management of sciatica. *Ann Intern Med*. 2012;157:865-877.

96. Plastaras C, McCormick Z, Macron D, et al. Adverse events associated with fluoroscopically guided zygapophyseal joint injections. *Pain Physician.* 2014;17:297-304.

97. Rados I, Sakic K, Fingler M, Kapural L. Efficacy of interlaminar vs transforaminal epidural steroid injection for the treatment of chronic unilateral radicular pain: prospective, randomized study. *Pain Med.* 2011;12(9):1316-1321.

98. Schreiber A, McDonald B, Kia F, Fried G. Cervical epidural steroid injections and spinal cord injuries. *Spine J*. 2016;16:1163-1166.

99. Sinofsky A, Aydin S, Kim E, Gharibo C. Concordant provocation as a prognostic indicator during interlaminar lumbosacral epidural steroid injections. *Pain Physician.* 2014;17:247-253.

100. Smith H, Colson J, Sehgal N. An update of evaluation of intravenous sedation on diagnostic spinal injection procedures. *Pain Physician.* 2013;16:SE217-SE228.

101. Society of Interventional Radiology (SIR). Percutaneous management of osteoarthritis in the knee: proceedings from the Society of Interventional Radiology Research Consensus Panel. https://www.sirweb.org. Published 2021.

102. Timpone V, Hirsch J, Gilligan C, Chandra R. Computed tomography guidance for spinal intervention: basics of technique, pearls, and avoiding pitfalls. *Pain Physician.* 2013;16:369-377.

103. Torkian P, Golzarian J, Chalian M, et al. Osteoarthritis-related knee pain treated with genicular artery embolization. *Orthop J Sports Med.* 2021;9(7):1-15.

104. UpToDate, Inc. Acute lumbosacral radiculopathy: treatment and prognosis. https://www.uptodate.com. Updated May 2024.

105. UpToDate, Inc. Chronic pelvic pain in adult females: treatment. https://www.uptodate.com. Updated May 2024.

106. UpToDate, Inc. Coccydynia (coccygodynia). https://www.uptodate.com. Updated June 14, 2027.

107. UpToDate, Inc. Complex regional pain syndrome in adults: treatment, prognosis, and prevention. https://www.uptodate.com. Updated June 7, 2024.

108. UpToDate, Inc. Endoscopic ultrasound-guided celiac plexus interventions for pain related to pancreatic cancer. https://www.uptodate.com. Updated May 2024.

109. UpToDate, Inc. Iliotibial band syndrome. https://www.uptodate.com. Updated May 2024.

110. UpToDate, Inc. Interventional therapies for chronic pain. https://www.uptodate.com. Updated May 2024.

111. UpToDate, Inc. Investigational approaches to the management of osteoarthritis. https://www.uptodate.com. Updated May 2024.

112. UpToDate, Inc. Lumbar spinal stenosis: treatment and prognosis. https://www.uptodate.com. Updated May 2024.

113. UpToDate, Inc. Management of moderate to severe knee osteoarthritis. https://www.uptodate.com. Updated May 2024.

114. UpToDate, Inc. Management of non-radicular neck pain in adults. https://www.uptodate.com. Updated May 2024.

115. UpToDate, Inc. Musculoskeletal ultrasonography: guided injection and aspiration of joints and related structures. https://www.uptodate.com. Updated May 2024.

116. UpToDate, Inc. Overuse (persistent) tendinopathy: overview of management. https://www.uptodate.com. Updated May 2024.

117. UpToDate, Inc. Overview of anesthesia. https://www.uptodate.com. Updated May 2024.

118. UpToDate, Inc. Overview of peripheral nerve blocks. https://www.uptodate.com. Updated May 16, 2024.

119. UpToDate, Inc. Post-herniorrhaphy groin pain. https://www.uptodate.com. Updated May 2024.

120. UpToDate, Inc. Postherpetic neuralgia. https://www.uptodate.com. Updated June 3, 2024.

121. UpToDate, Inc. Subacute and chronic low back pain: nonsurgical interventional treatment. https://www.uptodate.com. Updated May 15, 2024.

122. UpToDate, Inc. Treatment and prognosis of cervical radiculopathy. https://www.uptodate.com. Updated May 2024.

123. UpToDate, Inc. Treatment of acute low back pain. https://www.uptodate.com. Updated May 2024.

124. UpToDate, Inc. Treatment of fibromyalgia in adults. https://www.uptodate.com. Updated May 2024.

125. UpToDate, Inc. Ultrasound for peripheral nerve blocks. https://www.uptodate.com. Updated May 2024.

126. US Department of Veterans Affairs (VA). VA/DoD Clinical Practice Guidelines. Diagnosis and treatment of low back pain. https://www.va.gov. Published 2022.

127. US Department of Veterans Affairs (VA). VA/DoD Clinical Practice Guidelines. Non-surgical management of hip & knee osteoarthritis. https://www.va.gov. Published 2020.

128. Wewalka M, Abdelrahimsal A, Wiesinger G, Uher E. CT-guided transforaminal epidural injections with local anesthetic, steroid, and tramadol for the treatment of persistent lumbar radicular pain. *Pain Physician*. 2012;15:153-159.

Appendix

Use the hyperlinks below to return to the Coverage Determination section for a particular injection:

Epidural Steroid Injections
Facet Joint Injection/Medial Branch Block
Regional Sympathetic Nerve Block
Sacroiliac Joint Injection
Trigger Point Injections

Use the hyperlinks below to return to the Coverage Limitations section for the following:

Other Miscellaneous Injections
Peripheral Nerve Blocks
Dry Needling of Trigger Points

Appendix A – Definitions

Anatomical Region – For the purpose of pain injections, there are 2 anatomical regions of the spine (defined as (1) the cervical and thoracic spine and (2) the lumbar and sacral spine).

Maximum Number of Nerve Root Levels for ESI –

- Caudal and interlaminar: injection at only 1 nerve root level per session, **AND** only 1 anatomical region per session **AND** not in conjunction with a transforaminal injection.
- Transforaminal/SNRB: no more than 2 injections per session (a single nerve root level bilaterally or 2 nerve root levels unilaterally) **AND** only one anatomical region per session.

Moderate Sedation – Moderate sedation services are provided by the same physician or other qualified health care professional who is performing the diagnostic or therapeutic procedure that the sedation supports; this requires the presence of an independent trained observer (eg, circulating nurse) to assist in the monitoring of the individual's level of consciousness and vital signs.

Pain Scale – The scales used to measure of pain and/or disability must be documented in the medical record. Acceptable scales include but are not limited to: verbal rating scales, Numerical Rating Scale (NRS) and Visual Analog Scale (VAS) for pain assessment, and Pain Disability Assessment Scale (PDAS), Oswestry Disability Index (ODI), Oswestry Low Back Pain Disability Questionnaire (OSW), Quebec Back Pain Disability Scale (QUE), Roland Morris Pain Scale, Back Pain Functional Scale (BPFS), and the PROMIS profile domains to assess function.

Radicular/Radiculopathy – In low back pain, radicular means pain and/or numbness that radiates below the knee (this may also be referred to as lumbar radiculopathy)[15]; in neck pain, it is pain, numbness or weakness in the shoulder, arm, wrist or hand (this may also be referred to as cervical radiculopathy).[7]

Rolling 12 Month Period – A rolling 12 month period is 12 months after an event, regardless of what month the initial event took place (eg, first diagnostic injection is given August 1, 2024, the rolling 12 month period would end July 31, 2025).

Session – A session is defined as any and all epidural steroid injections or spinal procedures/injections performed on a single calendar day.

Sympathetic Blocks – Sympathetic blocks include stellate ganglion blocks in the neck and lumbar sympathetic blocks for lower extremity pain.

Change Summary

01/01/2025 New Policy.