2025 Evolent Clinical Guidelines for Medical Necessity Review

INTERVENTIONAL PAIN MANAGEMENT GUIDELINES

Effective July 1, 2025 – July 1, 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.

2. Kreiner D S, Hwang S, Easa J, Resnick D K, Baisden J et al. North American Spine Society (NASS): Clinical guidelines for diagnosis and treatment of lumbar disc herniation with radiculopathy. 2012; Accessed: September 10, 2024. https://www.spine.org/Portals/0/Assets/Downloads/ResearchClinicalCare/Guidelines/LumbarDiscHerniation.pdf.

3. Manchikanti L, Abdi S, Atluri S, Benyamin R, Boswell M et al. An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations. Pain Physician. Apr 2013; 16: S49-283.

4. North American Spine Society (NASS). Lumbar Transforaminal Epidural Steroid Injections: Review and Recommendation Statement. SpineLine. 2013.

5. Sayed D, Grider J, Strand N, Hagedorn J M, Falowski S et al. The American Society of Pain and Neuroscience (ASPN) Evidence-Based Clinical Guideline of Interventional Treatments for Low Back Pain. Journal of pain research. 2022; 15: 3729-3832.

6. Orhurhu V, Chu R, Gill J. Failed Back Surgery Syndrome. StatPearls [Internet]. Updated 2023 May 1; Accessed: September 10, 2024. https://www.ncbi.nlm.nih.gov/books/NBK539777/.

7. Washington State Health Care Authority. Health Technology Assessment HTCC Spinal Injections: Findings and Decision. 2016; Accessed: September 11, 2024. https://www.hca.wa.gov/assets/program/spinal_injections-rr_final_findings_decision_060216.pdf.

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

Guideline Number: Evolent_CG_1751	**Applicable Codes**	
"Evolent" refers to Evolent Health LLC and Evolent Specialty Services, Inc. 		
Original Date: May 2022	**Last Revised Date:** December 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)] and indications, contraindications and exclusions for single injection intraspinal drug trials for intrathecal pumps.

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

Scope

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

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

Special Note

New Episode of Care

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

See Legislative Language for specific mandates in the **State of Washington.**

INDICATIONS FOR INITIAL EPIDURAL SPINAL INJECTIONS/NERVE BLOCKS

General to all Caudal, Interlaminar and Transforaminal Injections

- Fluoroscopic guidance should be used for caudal and interlaminar injections and is necessary for transforaminal injections.
- For all injections, patients must exhibit pain causing functional disability or average pain level of ≥ 6 on a scale of 0 to 10 [2,3,4] 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 Epidural Spinal Injections

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

Initial Treatment Phase

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

Therapeutic Phase

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

Contraindications for Epidural Spinal Injections

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

INDICATIONS FOR INTRASPINAL DRUG TRIAL

Chronic Intractable Pain in Non-Terminal Individuals

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

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

Spasticity in Non-Terminal Individuals

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

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

Additional Trials

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

- Less than 50% pain relief
- Intolerable side effects

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

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

Contraindications for Intraspinal Drug Trial

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

EXCLUSIONS

These requests are excluded from consideration under this guideline:

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

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:

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 active and one 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 408 Epidural Spine Injections and Single Injection Trials For Intrathecal Pumps
January 2024	• Added conservative tx language • Added legislative language for WA state • Added criteria for additional intrathecal trials

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Specialty 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.

2. Kreiner D S, Hwang S, Easa J, Resnick D K, Baisden J et al. North American Spine Society (NASS): Clinical guidelines for diagnosis and treatment of lumbar disc herniation with radiculopathy. 2012; Accessed: September 10, 2024. https://www.spine.org/Portals/0/Assets/Downloads/ResearchClinicalCare/Guidelines/LumbarDiscHerniation.pdf.

3. Manchikanti L, Abdi S, Atluri S, Benyamin R, Boswell M et al. An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations. Pain Physician. Apr 2013; 16: S49-283.

4. North American Spine Society (NASS). Lumbar Transforaminal Epidural Steroid Injections: Review and Recommendation Statement. SpineLine. 2013.

5. Sayed D, Grider J, Strand N, Hagedorn J M, Falowski S et al. The American Society of Pain and Neuroscience (ASPN) Evidence-Based Clinical Guideline of Interventional Treatments for Low Back Pain. Journal of pain research. 2022; 15: 3729-3832.

6. Orhurhu V, Chu R, Gill J. Failed Back Surgery Syndrome. StatPearls [Internet]. Updated 2023 May 1; Accessed: September 10, 2024. https://www.ncbi.nlm.nih.gov/books/NBK539777/.

7. McIntyre A, Mays R, Mehta S, Janzen S, Townson A et al. Examining the effectiveness of intrathecal baclofen on spasticity in individuals with chronic spinal cord injury: A systematic review. The Journal of Spinal Cord Medicine. 2014; 37: 11 - 18. 10.1179/2045772313Y.0000000102.

8. Saulino M, Ivanhoe C, McGuire J, Ridley B, Shilt J. Best Practices for Intrathecal Baclofen Therapy: Patient Selection. Neuromodulation. 2016; 19: 607 - 615. 10.1111/ner.12447.

9. Washington State Health Care Authority. Health Technology Assessment HTCC Spinal Injections: Findings and Decision. 2016; Accessed: September 11, 2024. https://www.hca.wa.gov/assets/program/spinal_injections-rr_final_findings_decision_060216.pdf.

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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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

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

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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

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

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

Disclaimer

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Evolent Clinical Guideline 1756 for Sacroiliac Joint Injections

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

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STATEMENT

General Information

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

Special Note

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

See Legislative Language for specific mandates in Washington

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

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

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

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

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

Spondyloarthropathy [8]

ALL of the following must be met:

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

Imaging Guidance [3,4]

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

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

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

Diagnostic Purposes for Surgical Planning [3,6]

For diagnostic purposes, all the following must be met:

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

Repeat Injections [1,3,6]

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

Initial Treatment Phase

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

Therapeutic Phase

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

EXCLUSIONS

These requests are excluded from consideration under this guideline:

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

CONTRAINDICATIONS [2,3,4]

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

LEGISLATIVE LANGUAGE

Washington

20160318B – Spinal Injections [10]

Number and Coverage Topic:

20160318B – Spinal Injections

HTCC Coverage Determination:

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

HTCC Reimbursement Determination:

Limitations of Coverage:*

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

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

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

Non-Covered Indicators:

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

CODING AND STANDARDS

Coding

CPT Codes

27096, G0260

Applicable Lines of Business

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

BACKGROUND

Definitions

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

Risks associated with SIJ dysfunction [3,4]:

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

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

Sacroiliac joint injections are typically used for the following conditions:

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

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

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

Medical Necessity

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

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

Home Exercise Program (HEP)** [13]

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

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

AND

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

POLICY HISTORY

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

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

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Specialty Clinical Guideline Review Committee

Disclaimer

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Evolent Clinical Guideline 1752 for Implantable Infusion Pump Insertion

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

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

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

INDICATIONS

Intraspinal Drug Trial

Chronic Intractable Pain in Non-Terminal Individuals

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

- Pain causing functional disability that significantly interferes with activities of daily living, including ability to work and overall quality of life [(1)] **OR** persistent pain level of ≥ 6 on a scale of 0 to 10 despite treatment
- Failure to respond to non-operative conservative therapy targeting the requested spinal region for a minimum of 12 weeks unless the medical reason this treatment cannot be done is clearly documented

Spasticity in Non-Terminal Individuals

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

- Intractable spasticity that results in the individual's inability to maintain an upright posture, severely impairs balance in ambulation, or significantly interferes with activities of daily living related to **ONE** of the following conditions [(2,3)]:
  - Spinal cord injury
  - Multiple sclerosis
  - Stiff person syndrome
  - Other medical conditions causing intractable spasms
- Failure to respond to a minimum of 12 weeks of non-operative conservative therapy (e.g., oral medications, physical therapy, etc.)

Additional Trials

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

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

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

Permanently Implanted Infusion Pump

Chronic Intractable Pain in Non-Terminal Individuals

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

- Pain causing functional disability that significantly interferes with activities of daily living, including ability to work and overall quality of life [(1)] **OR** persistent pain level of ≥ 6 on a scale of 0 to 10 despite treatment
- Failure to respond to non-operative conservative therapy targeting the requested spinal region for a minimum of 12 weeks unless the medical reason this treatment cannot be done is clearly documented
- At least 12 weeks of oral or transdermal opioid or nonopioid pain medications
- Documentation of a successful trial of intraspinal (intrathecal or epidural) medication administered as a bolus or by continuous infusion providing at least 50% pain relief with tolerable side effects
- Documentation of a completed psychological assessment prior to permanent pump insertion that documents the individual's cognitive ability, physical capability, and willingness to participate in implanted infusion pump therapy [(1)]

Spasticity in Non-Terminal Individuals

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

- Intractable spasticity that results in the individual's inability to maintain an upright posture, severely impairs balance in ambulation, or significantly interferes with activities of daily living related to **one** of the following conditions [(2,3)]:
  - Spinal cord injury
  - Multiple sclerosis
  - Stiff person syndrome
  - Other medical conditions causing intractable spasms
- Failure to respond to a minimum of 12 weeks of conservative therapy (e.g., oral medications, physical therapy, etc.)
- Documentation of a successful trial of intraspinal (intrathecal or epidural)

antispasmodic medication administered as a bolus or by continuous infusion providing at least 50% spasm relief with tolerable side effects

- Documentation of a completed psychological assessment prior to permanent pump insertion that documents the individual's cognitive ability, physical capability, and willingness to participate in implanted infusion pump therapy

Pump Replacement, Revision and Removal

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

- Loss of effectiveness (e.g., battery depletion)
- Intolerance by the individual
- Infection
- Painful generator site
- Patient demand
- Documentation of pump or catheter malfunction impairing function or safety
- **Other medical reason deemed appropriate for replacement, revision, or removal**

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

Contraindications for Implanted Infusion Pump

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

CODING AND STANDARDS

Coding

CPT Codes

62350, 62351, 62355, 62360, 62361, 62362

Applicable Lines of Business

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

BACKGROUND

Medical Necessity

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

POLICY HISTORY

Date	Summary
December 2024	• This guideline replaces Evolent Clinical Guideline 310 Implantable Infusion Pump Insertion
January 2024	• Added criteria for additional intrathecal trials • Expanded pump criteria to include non-opioid medical trials • Expanded replacement indications to also include revision and removal • Edited background

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Specialty Clinical Guideline Review Committee

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REFERENCES

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Evolent Clinical Guideline 1757 for Spinal Cord Stimulation

Guideline Number: Evolent_CG_1757	**Applicable Codes**	
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Original Date: August 2020	**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

Code 63650 is also applicable for dorsal root ganglion stimulation (DRG). DRG has specific advantages over SCS as it has better CRPS coverage and greater anatomical specificity allowing for improved coverage for specific areas of the body, such as pain in the foot, knee, hip, and groin — areas noted to be difficult for SCS. [1]

INDICATIONS

Spinal Cord Stimulation

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

- Duration of pain of at least 6 months [2]
- Pain causing functional disability or average pain level of ≥ 6 on a scale of 0 to 10 [2]
- Failure to respond to non-operative conservative treatment (e.g., medication trials, interventional procedures (e.g., sympathetic nerve blocks, epidural steroid injections)) for a minimum of 6 months unless the medical reason this treatment cannot be done is clearly documented [2,3]
- A completed psychological assessment that documents the following [2,4,5]:
    - Pain is not due to psychiatric disorders such as depression, anxiety, somatic symptom disorder, or sequelae of substance use
    - Satisfactory management of personality and psychiatric disorders
    - Satisfactory management of substance use disorder in recovery
    - Demonstration of cognitive ability to manage the stimulator
- Pain caused by at least **ONE** of the following [2,4,5]:
    - Failed spine surgery syndrome (FSSS) or post-laminectomy syndrome [6]
    - Complex regional pain syndrome (CRPS), type I or type II, meeting Budapest criteria
    - Chronic neuropathic pain of certain origins that falls into **ONE** of the following diagnoses:
        - Lumbosacral arachnoiditis
        - Post herpetic neuralgia
        - Radiculopathy

- Chronic ischemic leg pain
- Diabetic peripheral neuropathy [7]
- Phantom limb syndrome (stump pain)
- Peripheral neuropathy
- Chronic back pain (neuropathic pain) and not a surgical candidate
- Chronic, refractory angina pectoris, characterized by **ALL** the following:
  - Continued angina after percutaneous coronary intervention or coronary artery bypass graft
  - Not a candidate for further revascularization
  - Angina is NYHA (New York Heart Association) III (less than ordinary physical activity causes symptoms) or IV (symptoms present at rest)
  - Optimal pharmacotherapy for at least one month with failure to tolerate medications in indicated dosage or failure to respond adequately to indicated medications

Permanent Spinal Cord Stimulator [5,8]

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

- Documentation of a successful trial of the temporary SCS device providing at least 50% reduction in pain
- Significant functional improvement for a minimum duration of 3 days
- A medical reason for use of a permanent stimulator device from the temporary trial device must be clearly documented

Revision or Removal of Spinal Cord Stimulator Device

Indicated with **ONE** of the following:

- Migration of lead(s)
- Loss of effectiveness
- Intolerance by the individual
- Infection
- Painful generator site
- Development of neurological deficits
- Patient demand

CONTRAINDICATIONS [2,4]

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

- Pregnancy

CODING AND STANDARDS

Coding

CPT Codes

63650, 63655, 63661, 63662, 63663, 63664, 63685, 63688

Applicable Lines of Business

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

BACKGROUND

Definitions [4,5,8]

The most common indication for spinal cord stimulator (SCS) placement is chronic pain from failed spine surgery syndrome. SCS is a minimally invasive, non-opioid alternative therapy used for the treatment of chronic neuropathic pain or ischemic pain. SCS has been well established as a safe and effective treatment of pain derived from a wide variety of etiologies. For individuals with chronic pain who have failed conservative approaches, SCS should be considered among other options before prescribing long-term opioids.

SCS is used to treat some common indications to include, but not limited to, failed spine surgery syndrome (FSSS), complex regional pain syndrome, painful peripheral vascular disease, and intractable angina. Limited literature suggests that SCS may also be beneficial for individuals with visceral abdominal and perineal pain and for painful diabetic neuropathy.

Based primarily on differences in clinical observations, SCS therapies can be categorized into at least two modalities to include paresthesia SCS (classical SCS) and sub-perception SCS (e.g., burst, kHz). Paresthesia SCS is generally characterized by programming stimulation parameters (including electric field configuration) between metal contacts residing in the epidural space such that the individual experiences paresthesia and the paresthesia topography overlaps the pain topography as much as possible.

Medical Necessity

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

Home Exercise Program (HEP)** [9]

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

Date	Summary
January 2024	• Adjusted psychological section to address pain is not due to psychiatric disorders, personality disorders and substance use disorders are being managed • Adjusted conservative treatment language in body and background sections • 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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Evolent Clinical Guideline 1758 for Sympathetic Nerve Blocks

Guideline Number: Evolent_CG_1758	**Applicable Codes**	
"Evolent" refers to Evolent Health LLC and Evolent Specialty Services, Inc. 		
Original Date: November 2020	**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 focuses on the utilization management of sympathetic nerve blocks for the diagnosis and acute and chronic management of sympathetically maintained pain for specific indications.

Special Note

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

New Episodes of Care

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

INDICATIONS

General Indications

- Acute or chronic noncancer pain causing functional disability or average pain level of ≥ 6 on a scale of 0 to 10 prior to injection **AND** continuation of pain or functional disability after the relief period due to the block
- Cancer pain affecting quality of life prior to injection and continuation after the relief period due to the block [(1)]

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

NOTE: Each block must be performed under image guidance [(2,3)]

Indications for Stellate Ganglion Block

Applies to face, upper extremities and upper thoracic region [4]

Diagnostic Evaluation or Acute Management of Sympathetically Maintained Pain Resulting From:

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

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

Diagnostic Evaluation, Acute or Chronic Management of Sympathetically Maintained Pain Resulting From:

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

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

General Limitations

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

Contraindications

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

- Allergy to anesthetic medication

Indications for Thoracic or Lumbar Sympathetic Block

Applies to thoracic region and lower extremities [4]

Diagnostic Evaluation or Acute Management of Sympathetically Maintained Pain Resulting From:

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

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

Diagnostic Evaluation, Acute or Chronic Management of Sympathetically Maintained Pain Resulting From:

- Complex regional pain syndrome types I and II [9] meeting Budapest criteria, **AND**
  - Failure to respond to functional restoration modalities which may include physical therapy, occupational therapy, or pain psychology modalities (e.g. rehabilitation strategies such as desensitization, range of motion, biofeedback, etc) or clearly documented medical reason the patient is unable to participate
  - Active participation in ongoing functional restoration or a clearly documented medical reason the treatment cannot be done[2]
- The previous block resulted in at least 50% relief or significant documented functional improvement for at least the duration of the anesthetic

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

General Limitations

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

Contraindications

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

Indications for Celiac Plexus Block

Applies to the upper abdomen [4]

For The Diagnostic Evaluation of Sympathetically Maintained Visceral Pain

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

For the Acute or Chronic Management of Sympathetically Maintained Visceral Pain Resulting From:

- Acute pancreatitis, **OR**
- Chronic, relapsing pancreatitis [2] **AND**
  - Failure to respond to nonoperative conservative treatment pertinent to the diagnosis or a clearly documented medical reason the conservative treatment cannot be done
- If the first injection is unsuccessful, a second initial injection may be performed in the initial phase for a maximum of 2 injections.
- After the initial phase, a therapeutic block may be performed every 3 months in a 12-month period
- The previous block resulted in at least 50% relief or significant documented functional improvement for at least the duration of the anesthetic
- Each therapeutic block resulted in at least 50% relief for a duration of 3 months

General Limitations

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

Contraindications

- Patient refusal
- Local or systemic infection
- Coagulopathy, hypotension or recent myocardial infarction

- Contralateral pneumothorax
- Allergy to anesthetic medication
- Abnormal anatomy

Indications for Superior Hypogastric Block

Applies to the pelvic and rectal regions [4]

For The Diagnostic Evaluation of Sympathetically Maintained Visceral Pain

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

For the Acute or Chronic Management of Sympathetically Maintained Visceral Pain Resulting From:

- Chronic noncancer pain of pelvic and rectal viscera [10] **AND**
  - Failure to respond to nonoperative conservative treatment pertinent to the diagnosis or a clearly documented medical reason the conservative treatment cannot be done
- If the first injection is unsuccessful, a second initial injection may be performed in the initial phase for a maximum of 2 injections.
- After the initial phase, a therapeutic block may be performed every 3 months in a 12-month period
- The previous block resulted in at least 50% relief or significant documented functional improvement for at least the duration of the anesthetic
- Each therapeutic block resulted in at least 50% relief for a duration of 3 months

General Limitations

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

Contraindications

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

Exclusions

These requests are excluded from consideration under this guideline:

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

CODING AND STANDARDS

Coding

CPT Codes

64510, 64517, 64520, 64530

Applicable Lines of Business

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

POLICY HISTORY

Date	Summary
December 2024	• This guideline replaces Evolent Clinical Guideline 404 Sympathetic Nerve Blocks • Removed indications for frostbite, embolism, vasospasm, hyperhidrosis, chronic nonsurgical neuropathic pain syndromes, nonsurgical vascular pain, and post-traumatic stress disorder
January 2024	• Expanded criteria to enumerate individual block types • Added exclusions • Clarified language on application for treatment of PTSD and emphasized need for psychiatric referral and care

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Specialty Clinical Guideline Review Committee

Disclaimer

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

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