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2026 Interventional Pain Management

Interventional Pain Management

PM-IPM-HH

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Epidural Injection, Transforaminal, Interlaminar or Caudal Related National Coverage Determination (NCD)/Local Coverage Determination (LCD)

Please refer to https://www.cms.gov/medicare-coverage-database/search.aspx if applicable to the individual's healthplan membership.

Type/ID Number	Title
LCD 33461	Implantable Infusion Pump
LCD 33906	Epidural Steroid Injections for Pain Management
LCD 36920	Epidural Steroid Injections for Pain Management
LCD 38994	Epidural Steroid Injections for Pain Management
LCD 39015	Epidural Steroid Injections for Pain Management
LCD 39036	Epidural Steroid Injections for Pain Management
LCD 39054	Epidural Steroid Injections for Pain Management
LCD 39240	Epidural Steroid Injections for Pain Management

Clinical Judgment

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Epidural Injection, Transforaminal, Interlaminar or Caudal Epidural Injection Guideline

A transforaminal, interlaminar or caudal epidural injection is considered medically appropriate when the documentation demonstrates **ALL** of the following:

1. Clinical condition includes **ANY** of the following:
    a. Degenerative lumbar spondylolisthesis with neurological signs and/or deficits (eg, back/leg pain, motor)
    b. Failed back surgery syndrome (FBSS) or epidural fibrosis
    c. Spinal stenosis (foraminal, central or disc disease)
2. Computed tomography (CT) or fluoroscopic guidance to be used with procedure.
3. Pain and **ALL** of the following:
    a. Conservative therapy for *at least 4 weeks* failed or was poorly tolerated that includes **ALL** of the following: (*__NOTE:__ *Medical reason that physical therapy requirement cannot be done or completed must be clearly documented.*)
        i. Active treatment includes supervised physical therapy (PT) and/or chiropractic care
        ii. Medication treatment includes **ANY** of the following:
            A. Disease specific medications (eg, anti rheumatics)
            B. Oral pain medications
    b. Functional disability resulting from pain
    c. Radicular pain, acute or chronic, with or without motor weakness

References: [23] [36] [31] [32] [30] [35] [10] [27] [24] [12] [16]

Repeat Epidural Injection(s) Guideline

A repeat transforaminal, interlaminar or caudal epidural injection is considered medically appropriate when the documentation demonstrates **ALL** of the following:

1. Repeat injection for **ANY** of the following:
    a. Diagnostic injections (with or without steroids) may be given up to 2 times, with a minimum of *2 weeks* apart.
    b. Therapeutic injections may be given at least *10 weeks* apart, provided that at least 50% pain relief was achieved from the prior injection(s) for *at least 10 weeks*, with a maximum of 4 injections per year, per region.
2. Pain continues and/or documented functional disability
3. Engaged in active conservative non-operative treatment (supervised PT, chiropractic care) unless documentation supports that pain prevents participation.

References: [16] [30] [32] [23]

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Selective Nerve Root Block (SNRB) Guideline

A diagnostic selective nerve root block (SNRB), performed at a single or multiple levels and involving the introduction of anesthetic only, is considered medically appropriate when the documentation demonstrates **ALL** of the following:

1. Neurologic examination, radiological studies or electrodiagnostic studies are completed.
2. **NO** known pain diagnosis, as part of attempting to establish the diagnosis of radicular pain (eg, radiculitis or radiculopathy), and **ANY** of the following:
    a. Nerve root disease is suspected from clinical findings.
    b. Pre-surgical planning is indicated.

References: [12] [30] [3] [36]

Epidural Steroid Injection Contraindications

Absolute contraindications to transforaminal, interlaminar or caudal epidural steroid injections include **ANY** of the following:

- Allergy or hypersensitivity to injection contents (eg, anesthetic, contrast dye, corticosteroid)
- Bleeding or clotting disorder, uncontrolled
- Infection, local (injection site) or systemic
- Malignancy at the injection site
- Pregnancy
- Refusal by individual or legal designee
- Spondylosis, infectious

References: [36] [11]

Relative contraindications to transforaminal, interlaminar or caudal epidural steroid injections include **ANY** of the following:

- Cauda equina syndrome or myelopathy
- Comorbid condition that is uncontrolled (eg, congestive heart failure, Cushing syndrome, diabetes mellitus, liver disease).
- Immunosuppression, chronic
- Improvement with conservative treatment
- Spinal cord compression, acute
- Spinal stenosis, severe, for interlaminar injection **ONLY**

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References: [36] [11] [25]

Epidural Injection Procedure Codes

Table 1. Epidural Injection Associated Procedure Codes

CODE	DESCRIPTION
62320	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
62321	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)
62322	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)
64479	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level
64483	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level

Epidural Injection Summary of Changes

Epidural Injection guidelines from 2025 to 2026 had the following changes:

Table 1. 2026 Epidural Injection Summary of Changes

Date	Type of Change	Summary
03/04/2026	Mid-Cycle update	• Changed conservative therapy timeframe from "*at least 6 weeks* within the most *recent 6 months* failed or was poorly tolerated that includes **ALL** of the following: (***NOTE:** Individuals that progress/improve over the 6 weeks initial physical therapy period should continue PT for another 6 weeks before interventional consideration.*)" to "*at least 4 weeks* failed or was poorly tolerated that includes **ALL** of the following: (***NOTE:** Medical reason that physical therapy requirement cannot be done or completed must be clearly documented.*)" • Citations updated per the evidence. • Removed retired LCD: ▪ LCD 39242

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2026 Facet Joint Injection/Medial Branch Block Publication

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Cervical, Thoracic and/or Lumbar Spine Facet Joint Injections (FJI) and/or Medial Branch Blocks (MBB) Related National Coverage Determination (NCD)/Local Coverage Determination (LCD)

Please refer to https://www.cms.gov/medicare-coverage-database/search.aspx if applicable to the individual's healthplan membership.

Type/ID Number	Title
LCD 33930	Facet Joint Interventions for Pain Management
LCD 34892	Facet Joint Interventions for Pain Management
LCD 35936	Facet Joint Interventions for Pain Management
LCD 38765	Facet Joint Interventions for Pain Management
LCD 38773	Facet Joint Interventions for Pain Management
LCD 38801	Facet Joint Interventions for Pain Management
LCD 38841	Facet Joint Interventions for Pain Management

Clinical Judgment

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Cervical, Thoracic and/or Lumbar Spine Facet Joint Injections (FJI) and/or Medial Branch Blocks (MBB)

Initial Spine Facet Joint Injections (FJI)/Medial Branch Blocks (MBB) Guideline

Cervical, thoracic and lumbar facet joint injections and/or medial branch blocks are considered medically appropriate when the documentation demonstrates **ALL** of the following:

1. Pain with **ALL** of the following criteria met:
    a. Duration of at least *12 weeks*.
    b. Pain is causing functional disability (ie, limiting activities of daily living [ADL's])
    c. Non-radicular (cervical, lumbar, thoracic)
    d. Suggestive of facet joint origin, confirmed by provocative testing on physical examination (ie, pain exacerbated by extension and rotation, neck pain with referral to occiput, scapula or shoulders)
2. Computed tomography (CT), fluoroscopic or ultrasound guidance to be used with procedure.
3. Conservative management (unless contraindicated), and failure to respond or poorly responded to *at least 6 weeks* of conservative therapy and **ALL** of the following: (***NOTE:** Individuals that progress/improve over the *6 weeks initial* physical therapy period should continue PT for *another 6 weeks* before interventional consideration.)
    a. Active treatment includes **ANY** of the following:
        i. Chiropractic care
        ii. Supervised physical therapy (PT)
    b. Medication treatment includes **ANY** of the following:
        i. Disease specific medications (eg, anti-rheumatics)
        ii. Oral pain medications

References: [2] [4] [7] [10] [12] [13] [17] [30] [35] [22]

Repeat Facet Joint Injections/Medial Branch Blocks Guideline

Repeat facet joint injections/medial branch blocks are considered medically appropriate when the documentation demonstrates **ALL** of the following:

1. Administration will be at the same level as the initial block.

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2. Repeat injection is for **ANY** of the following:
    a. Diagnostic injections (maximum of 2 per region) may be performed when **ALL** of the following are true:
        i. At least 80% reduction in pain was achieved with initial injection.
        ii. Conservative management (unless contraindicated), and failure to respond or poorly responded to *at least 6 weeks* of conservative therapy and **ALL** of the following: (***NOTE:** Individuals that progress/improve over the *6 weeks initial* physical therapy period should continue PT for *another 6 weeks* before interventional consideration.)
            A. Active treatment includes **ANY** of the following:
                I. Chiropractic care
                II. Supervised physical therapy (PT)
            B. Medication treatment includes **ANY** of the following:
                I. Disease specific medications (eg, anti-rheumatics)
                II. Oral pain medications
    b. Therapeutic injections may be performed (maximum of 3 per region in a 12 month period) and **ALL** of the following:
        i. At least 50% reduction in pain was achieved with previous injection for *3 months*.
        ii. Conservative non-operative treatment (supervised physical therapy, chiropractic care) active engagement, unless documentation supports that pain prevents participation.

References: [7] [22]

Alternative to Radiofrequency Ablation/Neurotomy Guideline

A facet joint injection/medial branch block is considered a medically appropriate alternative to a radiofrequency ablation/neurotomy when the documentation demonstrates **ALL** of the following:

1. Initial facet joint injection/medial branch block resulted in significant reduction in pain (eg, more than 50%) for at least 12 weeks after the facet joint injection/medial branch block.
2. **NOT** a candidate for a radiofrequency joint denervation/ablation if **ANY** of the following apply:
    a. Presence of an implanted cardiac device (e.g., pacemaker or defibrillator
    b. Ongoing anticoagulation therapy

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c. Positive response to previous diagnostic injections (indicating alternative treatment is appropriate)

d. Young athletes (due to long-term considerations and alternative options)

References: [7]

Facet Joint Injection/Medial Branch Block Contraindications (Cervical, Thoracic, Lumbar)

Contraindications to cervical, thoracic and/or lumbar facet joint injections or medial branch blocks include **ANY** of the following:

- Allergy to any of the injection contents (eg, anesthetic, corticosteroids, contrast dye)
- Bleeding or clotting disorder that is uncontrolled.
- Infection, active
- Pregnancy, if ultrasound guidance is **NOT** available.
- Previous fusion was performed at the same level.
  References: [7] [18]

Facet Joint Injections/Medial Branch Blocks Procedure Codes

Table 1. Facet Joint Injections/Medial Branch Blocks Associated Procedure Codes

CODE	DESCRIPTION
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
0213T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; single level
0216T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; single level

Facet Joint Injections/Medial Branch Blocks Summary of Changes

Facet Joint Injections/Medial Branch Blocks guideline from 2025 to 2026 had the following changes:

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Table 1. 2026 Facet Joint Injections/Medial Branch Blocks Summary of Changes

Date	Type of Change	Summary
03/04/2026	Mid-Cycle up-date	• Changed: ▪ Under Alternative to Radiofrequency Ablation: ◦ "is **ANY** of the following apply" to "if **ANY** of the following apply" ▪ Under Repeat Facet Joint Injections and Medial Branch Blocks: ◦ "Conservative therapy for at least 6 weeks within the most recent 6 months failed or was poorly tolerated" to "Conservative management (unless contraindicated), and failure to respond or poorly responded to *at least 6 weeks* of conservative therapy" • Citations updated per the evidence. • Removed retired LCD: ▪ LCD 38803

2026 Radiofrequency Neurolysis, Paravertebral Facet Joint Publication

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Radiofrequency Neurolysis, Paravertebral Facet Joint/Medial Branch Transection Related National Coverage Determination (NCD)/Local Coverage Determination (LCD)

Please refer to https://www.cms.gov/medicare-coverage-database/search.aspx if applicable to the individual's healthplan membership.

Type/ID Number	Title
LCD 33930	Facet Joint Interventions for Pain Management
LCD 34892	Facet Joint Interventions for Pain Management
LCD 35936	Facet Joint Interventions for Pain Management
LCD 38765	Facet Joint Interventions for Pain Management
LCD 38773	Facet Joint Interventions for Pain Management
LCD 38801	Facet Joint Interventions for Pain Management

Type/ID Number	Title
LCD 38841	Facet Joint Interventions for Pain Management

Clinical Judgment

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Radiofrequency Neurolysis, Paravertebral Facet Joint/Medial Branch Transection

Radiofrequency Neurolysis, Paravertebral Facet Joint/Medial Branch Transection Guideline

Radiofrequency neurolysis (denervation/ablation) of a paravertebral facet joint **OR** a medial branch transection is considered medically appropriate when the documentation demonstrates **ALL** of the following:

1. Pain, present for at least 3 months and **ALL** of the following:
    a. Conservative therapy for *at least 6 weeks* within the most *recent 6 months* failed or was poorly tolerated that includes **ALL** of the following: (*__NOTE:__ *Individuals that progress/improve over the 6 weeks initial physical therapy period should continue PT for another 6 weeks before interventional consideration*.)
        1. Active treatment includes **ANY** of the following:
            a. Chiropractic care
            b. Supervised physical therapy (PT)
        2. Medication treatment includes **ANY** of the following:
            a. Disease specific medications (eg, anti rheumatics)
            b. Oral pain medications
    b. Functional disability resulting from pain
2. Procedure is performed using computed tomography (CT), fluoroscopy or ultrasound guidance.

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3. Up to two diagnostic facet joint injections/medial branch blocks that resulted in at least 50% relief of pain or improved function for at least 2-4 hours or the expected minimum duration of the local anesthetic used.

References: [8] [27] [9] [34] [19] [37] [10] [13] [1] [28] [14]

Repeat Radiofrequency Joint Neurolysis/Medial Branch Transection Guideline

Repeat radiofrequency joint neurolysis/medial branch transection (denervation/ablations) is considered medically appropriate when the documentation demonstrates **ALL** of the following:

- Engaged in active conservative non-operative treatment (supervised physical therapy, chiropractic care) unless documentation supports that pain prevents participation.
- Maximum of 2 procedures per region in a 12 month period
- Minimum of 6 months since the prior denervation/ablation at the same level
- Pain returned, at least 3 months following a previously successful procedure.

References: [6] [7]

Paravertebral Facet Joint Radiofrequency Neurolysis/Medial Branch Transection Contraindications

Contraindications to Paravertebral Facet Joint Radiofrequency Neurolysis/Medial Branch Transection include **ANY** of the following:

- Coagulopathy
- Infection, active
- Myopathy, acquired or congenital
- Neuromuscular disease, (eg, amyotrophic lateral sclerosis (ALS), severe myasthenia gravis)
- Pregnancy
- Previous spinal fusion at the same level
  Reference: [13]

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Radiofrequency Neurolysis, Paravertebral Facet Joint Procedure Codes

Table 1. Radiofrequency Neurolysis, Paravertebral Facet Joint Associated Procedure Codes

CODE	DESCRIPTION
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint

Radiofrequency Neurolysis, Paravertebral Facet Joint Summary of Changes

Radiofrequency Neurolysis Paravertebral Facet Joint guideline from 2025 to 2026 had the following changes:

Table 1. 2026 Radiofrequency Neurolysis Paravertebral Facet Joint Summary of Changes

Date	Type of Change	Summary
03/04/2026	Mid-Cycle update	• Citations updated per the evidence. • Evidence reviewed and indications remained the same. • Removed retired LCD: ▪ LCD 38803

2026 Sacroiliac Joint Injection

Interventional Pain Management

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Sacroiliac Joint Injection Related National Coverage Determination (NCD)/Local Coverage Determination (LCD)

Please refer to https://www.cms.gov/medicare-coverage-database/search.aspx if applicable to the individual's healthplan membership.

Type/ID Number	Title
LCD 35456	Nerve Blockade for Treatment of Chronic Pain and Neuropathy
LCD 39383	Sacroiliac Joint Injections and Procedures
LCD 39402	Sacroiliac Joint Injections and Procedures
LCD 39455	Sacroiliac Joint Injections and Procedures
LCD 39462	Sacroiliac Joint Injections and Procedures
LCD 39475	Sacroiliac Joint Injections and Procedures

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Sacroiliac Joint Injection

Diagnostic Sacroiliac Joint Injection Guideline

A diagnostic sacroiliac joint injection is considered medically appropriate when the documentation demonstrates **ALL** of the following:

1. One or more provocative test(s) is/are positive. [1]
2. Pain lasting for 3 months or greater and **ALL** of the following:
    a. Conservative management (unless contraindicated), and failure to respond or poorly responded to *at least 6 weeks* of conservative therapy and **ALL** of the following: (***NOTE:** Individuals that progress/improve over the *6 weeks initial* physical therapy period should continue PT for *another 6 weeks* before interventional consideration.)
        i. Active treatment includes **ANY** of the following:
            A. Chiropractic care
            B. Supervised physical therapy (PT)
        ii. Medication treatment includes **ANY** of the following:

[1]Sacroiliac provocative tests include compression, distraction; flexion, abduction and external rotation (FABER)/Patrick's test, Fortin finger sign, Gaenslen's test, log roll, sacral thrust, and thigh thrust.

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A. Disease specific medications (eg, anti-rheumatics)

B. Oral pain medications

b. Non-radicular, unilateral pain located below L5 and localized over the sacroiliac joint

3. Procedure is performed using computed tomography (CT) or fluoroscopic guidance.

References: [26] [21] [10] [20] [15] [33]

Therapeutic Sacroiliac Joint Injection Guideline

A therapeutic sacroiliac injection for sacroiliac joint pain is considered medically appropriate when the documentation demonstrates **ALL** of the following:

- 50% or more reduction in pain level was achieved with diagnostic injection.
- Conservative non-operative treatment (supervised physical therapy, chiropractic care) active engagement, unless documentation supports that pain prevents participation.
- Functional disability resulting from pain

References: [20] [26] [38]

Repeat Sacroiliac Joint Injection Guideline

Repeat injection(s) is/are considered medically appropriate when the documentation demonstrates **ALL** of the following:

1. Conservative non-operative treatment (supervised physical therapy, chiropractic care) active engagement, unless documentation supports that pain prevents participation.
2. Procedure is performed using computed tomography (CT) or fluoroscopic guidance.
3. Repeat injection(s) is/are for **ANY** of the following:
    a. Diagnostic injections (maximum of two [2] per region) may be performed if at least 75% reduction in pain was not achieved with the initial injection.
    b. Therapeutic injections may be performed (maximum of four (4) per region in a twelve (12) month period if at least 50% reduction in pain was achieved with the initial injection for at least 2 months.

References: [20] [5] [12] [21]

Contraindications for Sacroiliac Joint Injections

Contraindications to a sacroiliac joint injection include **ANY** of the following:

- Allergy to any of the injection contents (eg, anesthetic, corticosteroids, contrast dye)

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- Bleeding or clotting disorder that is uncontrolled.
- Infection, local (injection site) or systemic
- Pregnancy

References: [29] [38]

Sacroiliac Joint Injection Procedure Codes

Table 1. Sacroiliac Joint Injection Associated Procedure Codes

CODE	DESCRIPTION
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)
G0260	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography

Sacroiliac Joint Injection Summary of Changes

Sacroiliac Joint Injection guideline from 2025 to 2026 had the following changes:

Table 1. 2026 Sacroiliac Joint Injection Summary of Changes

Date	Type of Change	Summary

03/04/2026	Mid-Cycle update	• Citations updated per the evidence.
		• Evidence reviewed and indications remained the same.
		• Removed retired LCD:
		  ▪ LCD 35457
		  ▪ LCD 39464

Interventional Pain Management Summary of Changes

Interventional Pain Management guideline from 2025 to 2026 had the following changes:

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Table 1. 2026 Interventional Pain Management Summary of Changes

Date	Type of Change	Summary
03/04/2026	Mid-Cycle update	• Changed the following: ▪ Under Epidural Injection Guideline: ◦ "Conservative therapy for *at least 6 weeks* within the most *recent 6 months* failed or was poorly tolerated that includes **ALL** of the following: (*__NOTE:__ *Individuals that progress/improve over the 6 weeks initial physical therapy period should continue PT for another 6 weeks before interventional consideration*.)" to "Conservative therapy for *at least 4 weeks* failed or was poorly tolerated that includes **ALL** of the following: (*__NOTE:__ *Medical reason that physical therapy requirement cannot be done or completed must be clearly documented.*)". ▪ Under Alternative to Radiofrequency Ablation: ◦ "is **ANY** of the following apply" to "if **ANY** of the following apply" ▪ Under Repeat Facet Joint Injections and Medial Branch Blocks: ◦ "Conservative therapy for at least 6 weeks within the most recent 6 months failed or was poorly tolerated" to "Conservative management (unless contraindicated), and failure to respond or poorly responded to *at least 6 weeks* of conservative therapy" ▪ Citations updated per the evidence. ▪ Removed retired LCD: ◦ LCD 35457 ◦ LCD 38803 ◦ LCD 39242 ◦ LCD 39464
08/22/2025	Annual Review	• Changed the following: ▪ Under Radiofrequency Neurolysis, Paravertebral Facet Joint/Medial Branch Transection Guideline: ◦ "Two or less diagnostic facet joint injections/medial branch blocks that resulted in significant pain relief or improved function for at least the minimum expected duration of the local anesthetic used." to "Up to two diagnostic facet joint injections/medial branch blocks that resulted in at least 50% relief of pain or improved function for at least 2-4 hours or the expected minimum duration of the local anesthetic used." ◦ "Pain and ALL of the following" to "Pain, present for at least 3 months and ALL of the following" and removed additional criteria for Pain as it is redundant. ▪ Under Repeat Facet Joint Injections/Medial Branch Blocks:

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Date	Type of Change	Summary
		◦ "At least 70% reduction in pain was achieved with initial injection" to "At least 80% reduction in pain was achieved with initial injection" as per evidence based. • Added the following: ▪ Addition of pain parameter to Repeat Radiofrequency Joint Neurolysis/Medial Branch Transection Guideline: Pain returned, at least 3 months following a previously successful procedure as per evidence based. • Removed the following: ▪ Removed the indication **NO** clinical findings (including imaging) support an alternative cause of the pain (eg, central spinal stenosis, foraminal stenosis or disc herniation, fracture, infection, previous spinal instrumentation, pseudoarthrosis, tumor). As per evidence based.

Interventional Pain Management Definitions

Activities of daily living (ADLs) refer to basic self-care tasks that individuals perform to maintain their well-being and live independently. These tasks include:

- Bathing or showering
- Dressing
- Eating
- Toileting
- Transferring (getting in and out of bed or chair)

Cauda equina syndrome is a neurologic emergency caused by compression of the nerve roots in the lumbar spine, leading to symptoms such as bowel and bladder dysfunction, saddle anesthesia, and varying degrees of motor and sensory loss in the lower extremities.

Caudal epidural steroid injection (CESI) is an the injection of contrast (absent allergy to contrast), followed by the introduction of corticosteroids and possibly a local anesthetic into the epidural space of the spine by inserting a needle through the sacral hiatus (under fluoroscopic guidance) into the epidural space at the sacral canal.

Chiropractic care is primarily focused on spinal manipulation and other manual therapies. It is used to treat conditions like acute low back pain, neck pain, tension headache, osteoarthritis, and fibromyalgia.

Compression test is a clinical test used to identify pain of sacroiliac origin, which consists of placing vertical pressure on the hip of a person lying on his or her side to spread the anterior superior iliac spines (ASIS).

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Computed tomography (CT) is an imaging test that uses X-rays with computer analysis to generate cross-sectional images of the internal structures of the body that can be displayed in multiple planes.

Conservative management is an approach to treating back pain, neck pain and related spinal conditions utilizing non-surgical treatment options, such as physical therapy, medication and injections.

Cushing syndrome is a disorder that occurs when your body makes too much of the hormone cortisol over a long period of time.

Distraction test is a clinical test used to identify pain of sacroiliac origin. The examiner is positioned behind the person with both hands over the lateral aspect of the pelvis and applies downward pressure through the anterior portion of the ilium, spreading the sacroiliac (SI) joints.

Electrodiagnostic refers to testing that applies neurophysiologic techniques for the evaluation of potential impairment of the nervous, neuromuscular and/or muscular systems.

Epidural fibrosis is excessive production of scar tissue near the root of a nerve, and usually occurs following spinal surgery.

Epidural steroid injection (ESI) involves the administration of corticosteroid via insertion of a needle into the epidural space surrounding the spinal nerve root. Injections may be performed as part of a diagnostic workup for radicular pain, or as a therapeutic modality when noninvasive treatment strategies have failed. Injections may be performed via an interlaminar approach, transforaminal approach, or caudal approach (through the sacral hiatus at the sacral canal). An epidural steroid injection should be performed with the use of fluoroscopic or CT guidance and the injection of a contrast, with the exception of an emergent situation or when fluoroscopic/CT guidance or the injection of contrast is contraindicated (eg, pregnancy).

Flexion, abduction and external rotation (FABER) test (Patrick's test) is a clinical pain provocation test using these three movements combined to assist in diagnosis of pathologies at the hip, lumbar and sacroiliac region.

Facet joint injections/medial branch blocks refer to the injection of local anesthetic and possibly a corticosteroid in the facet joint capsule or along the nerves supplying the facet joints from C2-3 to L5-S1. The injection/block applies directly to the facet joint(s) blocked and not to the number of nerves blocked that innervate the facet joint(s). Facet joint injection techniques have evolved primarily as a diagnostic tool for pain originating in these joints, but have been widely utilized to treat chronic pain shown to be of facet origin. Following confirmation of facet pathology using a diagnostic medial branch block, select patients may undergo a radiofrequency nerve ablation procedure.

Failed back surgery syndrome (FBSS) is a generalized term used to describe the condition of people who have not had a successful result with back or spine surgery and experience continued pain after surgery.

Fluoroscopy is a study of moving body structures, similar to an X-ray "movie." A continuous X-ray beam is passed through the body part being examined and is transmitted to a TV-like

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monitor so that the body part and its motion can be seen in detail. Fluoroscopy, as an imaging tool, enables physicians to look at many body systems, including the skeletal, digestive, urinary, respiratory, and reproductive systems.

Foraminal stenosis is the narrowing or tightening of the openings between the bones in the spine (the foramen).

Gaenslen's test can indicate the presence or absence of a sacroiliac joint lesions, pubic symphysis instability, hip joint pathology or L4 nerve root lesion. It can also stress the femoral nerve. It is performed by positioning the person supine at the edge of the side of the bed with the painful leg resting very near to the end of the bed, and resting symptoms are assessed; the leg furthest from the edge of the bed (non tested leg) is flexed 90 degrees at the hip and held by the clinician using one hand; the clinician passively positions the upper leg (test leg) into hyperextension at the hip so that it hangs over the edge of the table; and the clinician applies a further stretch to the test leg into hip extension and adduction up to six times while a flexion based counter force is applied to the flexed leg.

Glucocorticosteroid is a medication widely used for inflammatory and autoimmune diseases.

Immunosuppression is the deliberate reduction or inhibition of the immune system's ability to respond to antigens, typically achieved through medications or therapies, to prevent organ rejection or treat autoimmune diseases, but it increases the risk of infections and malignancies.

Interlaminar epidural steroid injection (ILESI) is an injection of contrast (absent allergy to contrast), followed by the introduction of a corticosteroid and possibly a local anesthetic into the epidural space of the spine either through a paramedian or midline interlaminar approach under fluoroscopic guidance.

Log roll test assesses for pathology within the hip joint, and can be used to isolate the patient's pathology to the hip as opposed to outside of the hip joint.

Medial Branch Transection or endoscopic rhizotomy is a procedure performed for chronic low back pain caused by inflammation or osteoarthritis of the lumbar facet joints.

Myasthenia gravis is a disease in which antibodies made by the immune system prevent certain nerve-muscle interactions. It causes weakness in the arms and legs, vision problems, and drooping eyelids or head.

Myopathy is a neuromuscular disorder in which the primary symptom is muscle weakness due to dysfunction of muscle fiber. Other symptoms of myopathy can include muscle cramps, stiffness, and spasm.

Nerve root disease, also known as radiculopathy, involves compression or irritation of nerve roots, leading to symptoms like pain, paresthesias, or weakness in the distribution of the affected nerve root.

Neurotomy is the division of a nerve, for the relief of neuralgia or for other purposes.

Non radicular pain refers to pain that does not involve nerve root irritation or compression and typically manifests as localized pain without sensory or reflex abnormalities that would suggest nerve root involvement. It is often described as mechanical, musculoskeletal, axial, or nonspecific

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neck pain, without clear serious underlying disease such as fracture, malignancy, or infection. Common causes include cervical strain, zygapophyseal (facet) joint pain, diskogenic pain, cervical spondylosis, and conditions like whiplash

Paravertebral facet joints, (aka, zygapophyseal joints or Z-joints) are the joints between the spinal vertebrae. They have been implicated as a source of chronic neck and low back pain with a prevalence of up to 70% in the cervical spine, and up to 30% in the lumbar spine. Neither physical exam nor imaging has adequate diagnostic power to confidently identify the facet joint as a pain source.

Physical therapy (PT), also known as physiotherapy, is a healthcare profession focused on improving or restoring physical function and movement, managing pain, and preventing or limiting physical disabilities. Physical therapists, or PTs, evaluate and treat individuals of all ages with a wide range of conditions, including injuries, illnesses, and disabilities. They use various techniques like exercise, manual therapy, and modalities like heat and ice to help patients achieve their functional goals.

Provocative test is any type of testing in which symptoms of a condition are intentionally caused or reproduced in a patient or other person presenting for evaluation.

Pseudoarthrosis is a term used to describe what happens when a spinal fusion is unsuccessful. This condition may cause no symptoms or may cause pain in the neck, back, arms or legs.

Radicular is of, relating to or involving a nerve root.

Radiculitis describes acute symptoms felt by patients whose spinal nerve roots are pinched, compressed, irritated or inflamed as they exit the spinal column.

Radiculopathy describes a range of symptoms, including pain, numbness and weakness, produced by the pinching of a nerve root in the spinal column.

Radiofrequency joint denervation/ablation (eg, facet neurotomy, facet rhizotomy) refers to the insertion of a radiofrequency probe towards the medial branch of the posterior primary rami, which supplies the innervation to the facet joints under fluoroscopic guidance. The radiofrequency electrode is then utilized to apply continuous heat for a period of time, typically 90-120 seconds. Thus coagulating the nerve supplying the joint with the intention of providing pain relief by denervating the painful facet joint.

Sacral thrust test is a provocative test in which pressure is applied to the back of the hips while lying face down (prone) on an examination table. The sacral thrust test is considered positive when this pressure reproduces pain.

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

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Selective nerve root block (SNRB) is a diagnostic injection of contrast (absent allergy to contrast) of a single nerve root to assist with surgical planning followed by the introduction of a local anesthetic by inserting a needle into the neuroforamen under fluoroscopic or computed tomography (CT) guidance.
Spinal cord compression occurs when pressure on the spinal cord prevents the nerves from functioning normally, causing deficits.
Spinal instrumentation is a method of straightening and stabilizing the spine after spinal fusion, by surgically attaching hooks, rods and wires to the spine in a way that redistributes stress on the bones and keeps them in proper alignment.
Spinal stenosis is a condition that occurs when the spaces in the spine narrow and create pressure on the spinal cord and nerve roots.
Spondylitis is inflammation of the vertebrae.
Spondylolisthesis is the forward displacement of a vertebra on the one below it and especially of the fifth lumbar vertebra on the sacrum producing pain by compression of nerve roots.
Thigh thrust test is a provocative test where the person lays in a supine position while the tested-side hip joint was flexed to approximately 90° by the examiner. An anteroposterior shear force is applied to the sacroiliac joint (SIJ) through the axis of the femur. Resulting pain indicates that the test is positive.
Transforaminal epidural steroid injection (TFESI) is a therapeutic injection of contrast (absent allergy to contrast) performed at a single or multiple spinal levels followed by the introduction of a corticosteroid and possibly a local anesthetic by inserting a needle into the neuroforamen under fluoroscopic or computed tomography (CT) guidance.

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Disclaimer section

Purpose

The purpose of the HealthHelp's clinical guidelines is to assist healthcare professionals in selecting the medical service that may be appropriate and supported by evidence to safely improve outcomes. Medical information is constantly evolving, and HealthHelp reserves the right to review and update these clinical guidelines periodically. HealthHelp reserves the right to include in these guidelines the clinical indications as appropriate for the organization's program objectives. Therefore the guidelines are not a list of all the clinical indications for a stated procedure, and associated Procedure Code Tables may not represent all codes available for that state procedure or that are managed by a specific client-organization.

Clinician Review

These clinical guidelines neither preempt clinical judgment of trained professionals nor advise anyone on how to practice medicine. Healthcare professionals using these clinical guidelines are responsible for all clinical decisions based on their assessment. All Clinical Reviewers are instructed to apply clinical indications based on individual patient assessment and documentation, within the scope of their clinical license.

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Payment

The use of these clinical guidelines does not provide authorization, certification, explanation of benefits, or guarantee of payment; nor do the guidelines substitute for, or constitute, medical advice. Federal and State law, as well as member benefit contract language (including definitions and specific contract provisions/exclusions) take precedence over clinical guidelines and must be considered first when determining eligibility for coverage. All final determinations on coverage and payment are the responsibility of the health plan. Nothing contained within this document can be interpreted to mean otherwise.

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National and Local Coverage Determination (NCD and LCD)

NOTICE
To ensure appropriate review occurs to the most current NCD and/or LCD, always defer to https://www.cms.gov/medicare-coverage-database/search.aspx.

Background

National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) are payment policy documents outlined by the Centers for Medicare and Medicaid Services (CMS) and the government's delegated Medicare Audit Contractors (MACs) that operate regionally in jurisdictions.

CMS introduced variation between different jurisdictions/Medicare Audit Contractors (MACs) and their associated covered code lists with the transition to ICD 10. The variation resulted in jurisdictions independently defining how codes are applied for exclusions, limitations, groupings, ranges, etc. for the medical necessity indications outlined in the NCD and LCD. Due to this variation, there is an inconsistent use/application of codes and coverage determinations across the United States between the different MACs.

In addition, **WITHOUT** notice, CMS can change the codes that indicate medical necessity and the format of the coverage determinations/associated documents (eg, Articles). This is an additional

challenge for organizations to keep up with ongoing, unplanned changes in covered codes and medical necessity indications.

Medical Necessity Codes

Due to the variation in code application between jurisdictions/MACs and that updates can happen without notification, HealthHelp is not able to guarantee full accuracy of the codes listed for any Coverage Determination, and advises that prior to use, the associated Coverage Determination Articles are reviewed to ensure applicability to HealthHelp's programs and any associated NCDs and LCDs.

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