MEDICAL POLICY

Excellus
An independent licensee of the Blue Cross Blue Shield Association

Medical Policy Title	**Facet Joint Injections/ Medial Branch Blocks**
Policy Number	**7.01.116**
Current Effective Date	October 15, 2025
Next Review Date	June 2026

Our medical policies are based on the assessment of evidence based, peer-reviewed literature, and professional guidelines. Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract. (Link to Product Disclaimer)

POLICY STATEMENT(S)

Diagnostic Facet Joint Injection/Medial Branch Block

I. An initial diagnostic facet joint injection/medial branch block to determine whether chronic cervical, thoracic, or lumbar pain is of facet joint origin is considered **medically appropriate**, when **ALL** the following criteria are met:

   A. Presence of predominantly axial cervical, thoracic, or lumbar pain (i.e., C2 - C3 to L5 - S1);

   B. Pain has persisted for at least three (3) months;

   C. In the past three (3) months, pain has persisted despite at least four (4) weeks of appropriate conservative treatment (e.g., physical therapy, chiropractic care, exercise, medications such as nonsteroidal anti-inflammatory drugs [NSAIDs] or analgesics). If conservative treatment is contraindicated, the reason(s) for contraindication(s) is/are required to be documented in the medical record;

   D. Clinical findings and imaging studies suggest no other obvious cause of the cervical, thoracic, or lumbar axial pain (e.g., central spinal stenosis with neurogenic claudication/myelopathy, foraminal stenosis or disc herniation with concordant radicular pain/radiculopathy that has been treated, infection, tumor, fracture, pseudoarthrosis, or pain related to spinal instrumentation);

   E. No more than three (3) facet joint levels are being injected during the same session/procedure.

   F. The spinal motion segment is not posteriorly fused; and

   G. A radiofrequency joint denervation/ablation procedure is being considered.

II. A second diagnostic facet joint injection/medial branch block, performed to confirm the validity of the positive clinical response to the initial facet joint injection/medical branch block is considered **medically appropriate** when **ALL** the following criteria are met:

   A. The facet joint injection or medial branch block is administered at the same level(s) as the initial diagnostic injection;

   B. The initial diagnostic facet joint injection/medial branch block produced a positive response (i.e., at least 80% relief of facet-mediated pain for at least the expected minimum duration of the effect of the local anesthetic); and

C. A radiofrequency joint denervation/ablation procedure is being considered.

Therapeutic Facet Joint/Medial Branch Block- Alternative Treatment when Radiofrequency Ablation/Neurotomy is Contraindicated

III. The first therapeutic facet joint injections/medial branch blocks performed as an alternative treatment to a radiofrequency ablation/neurotomy are considered **medically necessary** when **ALL** the following criteria are met:

A. The individual is not a candidate for a facet joint radiofrequency denervation/ablation procedure due to **ONE** of the following contraindications:

1. Established spinal pseudoarthrosis at the spinal level intended for treatment, **or**
2. Implanted electrical device (i.e., cardiac pacemaker, cardiac defibrillator, dorsal column stimulator, dorsal root ganglion stimulator, peripheral neurostimulator, cranial neurostimulator, implantable programmable drug pump); **and**

B. There has been a documented positive response with two (2) sequential diagnostic facet joint injections/medial branch blocks at the same level(s). **Note**: a positive response is evidenced by at least 80% relief of facet mediated pain for at least the expected minimum duration of the effect of the local anesthetic used.

IV. Subsequent therapeutic facet joint injections/medial branch blocks performed as an alternative treatment to a radiofrequency ablation/neurotomy are considered **medically appropriate** when **ALL** the following criteria are met:

A. The individual is not a candidate for a facet joint radiofrequency denervation/ablation procedure due to **ONE** of the following:

1. Established spinal pseudoarthrosis at the spinal level intended for treatment; **or**
2. Implanted electrical device (e.g., cardiac pacemaker, cardiac defibrillator, dorsal column stimulator, dorsal root ganglion stimulator, peripheral neurostimulator, cranial neurostimulator, implantable programmable drug pump); **and**

B. Previous therapeutic facet joint injections/medial branch blocks, at the same level(s), resulted in at least 50% pain relief for at least 12 weeks following the facet joint injection/medial branch block; **and**

C. The prior therapeutic facet joint injection/medial branch block, at the same level(s), was performed at least six (6) months ago.

Intra-Articular (IA) Facet Joint Injection Performed with Synovial Cyst Aspiration

V. An initial intra-articular facet joint injection performed with synovial cyst aspiration, is considered **medically appropriate**, when **ALL** the following criteria are met:

A. Advanced diagnostic imaging studies (i.e., magnetic resonance imaging [MRI], computed tomography [CT] scan, CT myelogram) confirm compression or displacement of the corresponding nerve root by a facet joint synovial cyst; and

B. There is a clinical correlation (based on history and physical exam) with the individual's signs and symptoms of radicular pain/radiculopathy.

VI. If a repeat intra-articular (IA) facet joint injection with synovial cyst aspiration is needed the following is required:

A. The previous facet joint injections/medial ranch blocks resulted in at least 50% pain relief for at least 12 weeks following the facet joint injection/medial branch block.

VII. Performance of a facet joint injection or medial branch block is considered **not medically necessary** for **ANY** of the following indications:

A. The facet joint injection/medial branch block is performed without the use of fluoroscopic or CT guidance;

B. The facet joint injection/medial branch block is performed on the same day of service as other invasive modality or procedure (see Policy Guidelines for ~~the~~ criteria exception);

C. Facet joint injections/medial branch blocks are performed on more than three (3) contiguous spinal joint levels. Criteria exception: if the facet joint injection/medial branch block is performed above or below the posteriorly-fused spinal motion segment);

D. An additional diagnostic facet joint injection/medial branch block is being performed at the same level(s) as a prior successful radiofrequency denervation/ablation procedure;

E. The facet joint injection/medial branch block is of the atlanto-occipital articulation and/or atlanto-axial articulation (above C2-C3 and below L5-S1) as these are not facet joints;

F. Facet joint injection/medial branch block performed subsequent to the initial two (2) diagnostic injections (i.e., therapeutic injection), except when performed as an alternative treatment when radiofrequency ablation/neurotomy treatment is contraindicated (see Policy Statements).

VIII. Facet joint injection/medial branch block is considered **investigational** when **ANY** of the following apply:

A. Injectates other than anesthetic, corticosteroid, and/or contrast agent (e.g., biologics [platelet rich plasma, stem cells, amniotic fluid]) are administered alone or in combination;

B. The injection is performed under ultrasound guidance; or

C. Facet joint injections/medial branch blocks of the L5 - S1 facet joint, when ~~is~~ used for the diagnosis or treatment of sacroiliac (SI) joint mediated pain.

RELATED POLICIES

Corporate Medical Policy

7.01.42 Radiofrequency Facet and Sacroiliac Joint Ablation/Denervation, for requests related to L5 medial nerve branch and sacral lateral nerve branch blocks or ablation/neurotomies.

7.01.115 Epidural Steroid Injections

11.01.03 Experimental or Investigational Services

POLICY GUIDELINE(S)

I. This policy only applies to injections of an anesthetic, corticosteroid, and/or contrast agent and does not apply to injections of biologics (e.g., platelet rich plasma, stem cells, amniotic fluid, etc.) and/or any other injectates that are not in scope of management.

II. Facet joint injections/medial branch blocks should only be performed for either of the following:

   A. cervical, thoracic, or lumbar axial pain in the absence of an untreated radicular pain/radiculopathy; or

   B. treatment of facet joint synovial cyst with concordant radicular pain/radiculopathy.

III. Facet joint injections/medial branch blocks must be performed for facet-mediated pain and not for other indications and not for other indications that are not in scope of management (i.e., third occipital nerve [TON] injection/nerve block for cervicogenic headaches).

IV. Facet joint injections/medial branch blocks are not without risk and can expose individuals to potential complications that may be increased when a patient is sedated. As a result, when performing facet joint injections/medial branch blocks, the use of supplemental sedation in addition to local anesthesia is not required and not recommended

V. Only one invasive modality or procedure will be performed on the same date of service. Criteria exception: for an intra-articular facet joint injection being performed together with a transforaminal epidural steroid injection (TFESI) with synovial cyst aspiration on the same date of service.

VI. When criteria have been met, facet joint injections/medial branch blocks are only permitted from levels C2 - C3 to L5 - S1. Note: The facet joint injection/medial branch block applies directly to the facet joint(s) blocked/ablated and not to the number of nerves blocked/ablated that innervate the facet joint(s),

VII. A diagnostic facet joint injection/medial branch block may be performed to determine whether spinal pain originates in the facet joint or nerves surrounding the facet joint. A second diagnostic facet joint injection/medial branch block must be performed to confirm the validity of the positive response (i.e., at least 80% relief) of the initial injection/block.

   A. The second diagnostic facet joint injections/medial branch blocks should only be performed with the intent that, if successful, a radiofrequency joint denervation/ablation procedure (facet neurotomy, facet rhizotomy) would be considered as an option at the diagnosed level(s).

   B. Only two (2) diagnostic facet joint injections/medial branch blocks are permitted at the same level(s). **Note**: More than two (2) facet injections/medial branch blocks at the same level and same side are considered to be **therapeutic** rather than diagnostic and must meet the criteria for therapeutic facet joint injections/medial branch blocks.

VIII. It may be necessary to perform the facet joint injection/medial branch block at the same facet

joint level(s) bilaterally. However, no more than three (3) facet joint levels may be injected during the same session/procedure.

IX. Following a spinal fusion, a diagnostic facet joint injection/medial branch block may be performed immediately above or below the fused level, if a prior injection/block was negative at the requested level.

X. Requests for subsequent (beyond initial) facet joint injections/medial branch blocks will be evaluated based on the response to the prior facet injection/medial branch block. Therefore, a series of facet joint injections/medial branch blocks at the same level(s) is not permitted in one request.

DESCRIPTION

Definitions for Facet Joint Injections/ Medial Branch Blocks:

Axial is relating to or situated in the central part of the body, in the head and trunk as distinguished from the limbs, (e.g., axial skeleton).

Cervical facet pain is pain located in the cervical spine, which may be characterized by chronic headaches, restricted motion, and axial neck pain, which may radiate sub-occipitally to the shoulders or mid-back.

Facet joint pain is a set of concurrent signs or symptoms to describe the facet joint as the pain generator. The typical clinical signs or symptoms may include local paraspinal tenderness; pain that is brought about or increased on hyperextension, rotation, and lateral bending; low back stiffness; absence of neurologic deficit; absence of root tension signs (non- radiating below the knee, absence of paresthesia).

Facet (zygapophyseal) joints are paired, diarthrodial synovial joints located between the superior and inferior articular pillars in the posterior spinal column, innervated by medial branch nerves, from C2 - C3 to L5 - S1. Note: The articulations between occiput - atlas (C1) and the atlas (C1) and the axis (C2) and below L5 - S1 (sacrum) are not facet joints.

Facet level is the zygapophyseal joint or the two medial branch (MB) nerves that innervate that zygapophyseal joint. Each level has a pair of facet joints: one on the right side and one of the left side of the spine.

Facet joint injections/medial branch blocks is the injection of local anesthetic and possibly a corticosteroid in the facet joint capsule (facet joint injection) or along the nerves supplying the facet joints (medial branch block) from C2-C3 to L5-S1. Even though either procedure can be used to diagnose facet joint pain, a medial branch block is generally considered more appropriate. Note: The injection/block applies directly to the facet joint(s) blocked and not to the number of nerves block that innervate the facet joint(s).

Non-radicular back pain is radiating non-neuropathic pain which pain that is not causally related to a spinal nerve root irritation and does not produce reproducible neuropathic symptoms in an objective dermatomal pattern.

Positive response (to a diagnostic facet joint injection/medial branch block) is at least 80% relief of facet -mediated pain for at least the expected minimum duration of the effect of the local anesthetic used. Note: A response to the first two injection(s) must be documented.

Session is a time period, which includes all procedures (i.e., medial branch block (MBB), intra-articular facet joint injection, and radiofrequency ablation [RFA]) performed on a single date of service.

SUPPORTIVE LITERATURE

Generally, the outcomes from clinical studies reflect that a diagnostic facet joint injection may assist in determining whether specific interventions targeting the facet joint are indicated.

Manchikanti et al (2015) state that despite interventional procedures being common as treatment strategies for facet joint pathology, there is a paucity of literature investigating these therapeutic approaches. A systematic review and best evidence synthesis of the effectiveness of therapeutic facet joint interventions in managing chronic spinal pain was conducted to evaluate and update the clinical utility of therapeutic lumbar, cervical, and thoracic facet joint interventions in managing chronic spinal pain. A total of 21 randomized controlled trials (RCTs) and 5 observational studies were assessed. The limitations of this systematic review include an overall paucity of high-quality studies and the lack of investigations related to thoracic facet joint injections. Based on the present assessment for the management of spinal facet joint pain, the evidence for long-term improvement is Level II for therapeutic facet joint nerve blocks in the cervical, thoracic, and lumbar spine.

Wardhana et al (2022) acknowledge that a few studies have explored the effectiveness of facet interventions for chronic lumbar pain, but there has been no clear consensus of which procedures are more superior. In a meta-analysis, this study aimed to compare the effectiveness of corticosteroid injection (CI) and radiofrequency (RF) ablation for the treatment of lumbar facet joint (LFJ) pain. In total, 7 studies (n=552 patients) were included in the analysis. The corticosteroid agents were methylprednisolone in 4 trials, betamethasone in 2 trials, and dexamethasone in 1 trial. Pulsed RF was performed in 4 trials, whereas continuous RF was performed in 3 trials. Treatment with CI was associated with higher pain intensity score than RF ablation (3 trials; $p < 0.00001$), with substantial heterogeneity. Pain intensity scores at 6 months were significantly higher in patients treated with CI than RF ablation (7 trials, $p = 0.0002$), with substantial heterogeneity. The estimated effect of CI on pain intensity score at 12 months when CI was compared to RF ablation showed a statistically insignificant increase ($p = 0.08$), with substantial heterogeneity. Overall, the authors concluded that the pooled analysis from limited trials showed a benefit of RF to the improvement of pain intensity and functional disability when comparing RF with CI for the treatment of LFJ pain.

Pasuhirunnikorn et al (2023) evaluated the effect of prolonged concordant response and functional clinical improvement between lidocaine and bupivacaine for cervical medial branch block (CMBB) in chronic cervical facet syndrome. Sixty-two patients diagnosed with chronic cervical facet syndrome were randomized into either lidocaine or bupivacaine groups. The patients, pain assessor, and pain specialist were blinded. The therapeutic CMBB was performed under ultrasound guidance. Either 2% lidocaine or 0.5% bupivacaine with a volume of 0.5-1 milliliter (mL) per level was injected according to the patient's pain symptoms. The primary outcome was the duration of pain reduction by at least

50%. The Numerical Rating Scale (NRS) of 0-10 and the Neck Disability Index questionnaire were recorded. There was no significant difference in the duration of 50% and 75% pain reduction and Neck Disability Index between the lidocaine and bupivacaine groups. Lidocaine provided significant pain reduction up to 16 weeks ($P < 0.05$) and significant improvement in neck functional outcomes up to 8 weeks ($P < 0.01$) compared to the baseline. Bupivacaine yielded significant pain alleviation for up to 8 weeks for pain upon neck mobilization ($P < 0.05$) and demonstrated notable improvement in neck function up to 4 weeks ($P < 0.01$) compared to the baseline. CMBB using lidocaine or bupivacaine provided clinical benefits in prolonged analgesic effect and improving neck functions for chronic cervical facet syndrome. Lidocaine illustrated better performance and could be considered a local anesthetic of choice regarding the prolonged concordance response.

Manchikanti et al (2024) evaluated the effectiveness of facet joint nerve blocks as a therapeutic modality in managing chronic axial spinal pain of facet joint origin by conducting a systematic review and meta-analysis of randomized controlled trials (RCTs) and observational studies. The primary outcome measure was the proportion of patients with significant relief and functional improvement of greater than 50% of at least 3 months. Duration of relief was categorized as short-term (less than 6 months) and long-term (greater than 6 months). Despite the availability of multiple studies, the paucity of literature is considered as the major drawback. Based on the present systematic review and meta-analysis with 9 RCTs and 12 non-randomized studies, the evidence is Level II with moderate to strong recommendation for therapeutic facet joint nerve blocks in managing spinal facet joint pain.

PROFESSIONAL GUIDELINE(S)

In 2020, American Society of Interventional Pain Physicians (ASIPP) issued guidelines on the use of facet joint injections in the management of chronic spinal pain (Manchikanti 2020), recommending:

- Facet joint nerve blocks for diagnosis of facet joint pain is recommended with a moderate to strong strength of recommendation for the lumbar spine (evidence level I to II), moderate strength for the cervical spine (evidence level II), and moderate strength for the thoracic spine (evidence level II).
- Facet joint nerve blocks for treatment of facet joint pain is recommended with moderate strength for lumbar spine (evidence level II) and cervical spine (evidence level II), and weak to moderate strength for thoracic spine (evidence level III).
- Intraarticular injections for treatment of facet joint pain with is a weak strength recommendation with lower levels of evidence (level III, IV, and V evidence for the thoracic, lumbar, and cervical spine respectively).

The American Society of Regional Anesthesia and Pain Medicine convened a multispecialty, international working group and published a consensus practice guideline on interventions for lumbar facet joint pain (Cohen 2020). The expert panel concluded that lumbar medial branch radiofrequency ablation (RFA) may provide benefit to well-selected individuals, with medial branch blocks (MBB) being more predictive than IA injections. Some of the guideline recommendations include:

- A 3-month trial of different conservative treatments before facet joint interventions. (Grade C,

low level of certainty)

- MBB should be the prognostic injection of choice before RFA. IA injections may be used for both diagnostic and therapeutic purposes in some individuals (e.g., young people with inflammatory pain, people at risk of RFA complications). (Grade C, moderate level of certainty)
- Recommendation against the routine use of both therapeutic MBB and IA injections, acknowledging that there may be some contexts in which these can be useful (e.g., prolonged relief from prognostic blocks, contraindications to RFA). (Grade D, moderate level of certainty)
- Greater than 50% pain relief be used as the threshold for designating a prognostic block as positive but recognize that using higher cut-off values may result in higher RFA success rates. Secondary outcomes such as activity levels may also be considered when deciding whether to proceed with RFA. (Grade B, moderate level of certainty).

REGULATORY STATUS

Not Applicable

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
0213T (E/I)	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance; single level
0214T (E/I)	second level (List separately in addition to code for primary procedure)
0215T (E/I)	third and any additional level(s) (List separately in addition to code for primary procedure)
0216T (E/I)	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; single level
0217T (E/I)	second level (List separately in addition to code for primary procedure)
0218T (E/I)	third and any additional level(s) (List separately in addition to code for primary procedure)
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level

Code	Description
64491	second level (List separately in addition to code for primary procedure)
64492	third and any additional level(s) (List separately in addition to code for primary procedure)
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64494	second level (List separately in addition to code for primary procedure)
64495	third and any additional level(s) (List separately in addition to code for primary procedure)

HCPCS Codes

Code	Description
Not Applicable	

ICD10 Codes

Code	Description
Multiple Code	

REFERENCES

Allen TL, et al. Fluoroscopic percutaneous lumbar zygoapophyseal joint cysts rupture: a clinical outcome study. Spine. 2009;9(5):387-395.

Bogduk N. A narrative review of intra-articular corticosteroid injections for low back pain. Pain Med. 2005;6(4):287-296

Boswell MV, et al. A best-evidence systematic appraisal of the diagnostic accuracy and utility of facet (zygapophysial) joint injections in chronic spinal pain. Pain Physician. 2015;18:E497-E533.

Chou R, et al. Nonsurgical interventional therapies for low back pain: a review of the evidence for an American Pain Society clinical practice guideline. Spine. 2009 May 1;34(10):1078-1093.

Cohen SP, et al. Effectiveness of lumbar facet joint blocks and predictive value before radiofrequency denervation: The Facet Treatment Study (FACTS), a randomized, controlled clinical trial. Anesthesiology. 2018 Sep;129(3):517-535.

Cohen SP, et al. Multicenter study evaluating factors associated with treatment outcome for low back pain injections. Reg Anesth Pain Med. 2022 Feb;47(2):89-99.

Cohen SP, et al. Consensus practice guidelines on interventions for lumbar facet joint pain from a multispecialty, international working group. Reg Anesth Pain Med. 2020 Jun; 45(6):424-467.

Domingues L, et al. Is a combined programme of manual therapy and exercise more effective than usual care in patients with non-specific chronic neck pain? A randomized controlled trial. Clin Rehabil. 2019 Dec;33(12):1908-1918.

Furman MB and Johnson SC. Induced lumbosacral radicular symptom referral patterns: a descriptive study. Spine J. 2019 Jan;19(1):163-170.

Guzmán Pavón MJ, et al. Comparative effectiveness of manual therapy interventions on pain and pressure pain threshold in patients with myofascial trigger points. Clin J Pain. 2022 Dec 1;38(12):749-760.

Hidalgo B, et al. The efficacy of manual therapy and exercise for treating non-specific neck pain: A systematic review. J Back Musculoskelet Rehabil. 2017 Nov 6;30(6):1149 - 1169.

Hofmeister M, et al. Ultrasound- versus fluoroscopy-guided injections in the lower back for the management of pain: a systematic review. Eur Radiol. 2019 Jul;29(7):3401-3409.

Kennedy DJ, et al. Corticosteroid injections into lumbar facet joints: A prospective, randomized, double-blind placebo-controlled trial. Am J Phys Med Rehabil. 2018 Oct;97(10):741-746.

Kennedy DJ, et al. Intra-articular steroids vs saline for lumbar z-joint pain: a prospective, randomized, double-blind placebo-controlled trial. Pain Med. 2019 Feb 1;20(2):246-251.

Lakemeier S, et al. A comparison of intraarticular lumbar facet joint steroid injections and lumbar facet joint radiofrequency denervation in the treatment of low back pain: A randomized, controlled, double-blind trial. Anesth Analg. 2013;117:228-235.

Lee BS, et al. Utility of repeat magnetic resonance imaging in surgical patients with lumbar stenosis without disc herniation. Spine J. 2019 Feb;19(2):191-198.

Lin I, et al. What does best practice care for musculoskeletal pain look like? Eleven consistent recommendations from high-quality clinical practice guidelines: systematic review. Br J Sports Med. 2020 Jan:54(2):79-86. Epub 2019 Mar 2.

Ma L, et al. Evaluating the Extent of Ultrasound-Guided Cervical Selective Nerve Root Block in the Lower Cervical Spine: Evidence Based on Computed Tomography Images. J Pain Res. 2023 Mar;116:669-676.

Manchikanti L, et al. Effectiveness of lumbar facet joint nerve blocks in chronic low back pain: A randomized clinical trial. Pain Physician. 2001;4:101-117.

Manchikanti L, et al. Therapeutic cervical medial branch blocks in managing chronic neck pain: a preliminary report of a randomized, double-blind, controlled trial. Pain Physician. 2006;9(4):333-346.

Manchikanti L, et al. Lumbar facet joint nerve blocks in managing chronic facet joint pain: one-year follow-up of a randomized, double-blind controlled trial. Pain Physician. 2008;11(2):121-132. 48.

Manchikanti L, et al. Evaluation of lumbar facet joint nerve blocks in managing chronic low back pain: A randomized, double-blind, controlled trial with a 2-year follow-up. Int J Med Sci. 2010; 7:124-135.

Manchikanti L, et al. Comparative outcomes of a 2-year follow-up of cervical medial branch blocks in management of chronic neck pain: A randomized, double-blind controlled trial. Pain Physician. 2010; 13:437-450.

Manchikanti L, et al. Comparative effectiveness of a one-year follow-up of thoracic medial branch blocks in management of chronic thoracic pain: a randomized, double-blind active controlled trial. Pain Physician. 2010; 13(6): 535-48. PMID 21102966

Manchikanti L, et al. The role of thoracic medial branch locks in A randomized, double-blind, active control trial with a 2-year follow-up. Anesthesiol Res Pract. 2012; 2012:585806.

Manchikanti L, et al. Effectiveness of therapeutic lumbar transforaminal epidural steroid injections in managing lumbar spinal pain. Pain Physician. 2012;15:E199-245.

Manchikanti L, et al. Comparison of the efficacy of saline, local anesthetics, and steroids in epidural and facet joint injections for the management of spinal pain: A systematic review of randomized controlled trials. Surg Neurol Inter. 2015;6(5):S194-S235.

Manchikanti L, et al. A systematic review and best evidence synthesis of the effectiveness of therapeutic facet joint interventions in managing chronic spinal pain. Pain Physician. 2015;18:E535-E582.

Manchikanti L, 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 facet joint interventions 2020 guidelines. Pain Physician. 2020 May;23(3S):S1-S127.

Manchikanti L, et al. Effectiveness of facet joint nerve blocks in managing chronic axial spinal pain of facet joint origin: a systematic review and meta-analysis. Pain Physician. 2024 Feb;27(2):E169-E206.

Mesregah MK, et al. Clinical effectiveness of interlaminar epidural injections of local anesthetic with or without steroids for managing chronic neck pain: a systematic review and meta-analysis. Pain Physician. 2020 Jul;23(4):335-348.

North American Spine Society [Internet]. Coverage policy recommendations. Facet joint interventions. 2016 Oct [accessed 2025 Feb 19]. Available from: https://www.spine.org/Coverage

North American Spine Society [Internet]. Clinical Guidelines. Diagnosis and treatment of low back pain. 2020 [accessed 2025 Feb 19]. Available from: https://www.spine.org/shop?category=11

Oliveira C, et al. Epidural corticosteroid injections for lumbosacral radicular pain. Cochrane Database Syst Rev. 2020 Apr 9;4(4):CD013577.

Park KD, et al. Effect of medial branch block in chronic facet joint pain for osteoporotic compression fracture: one-year retrospective study. Ann Rehabil Med. 2013 Apr;37(2):191-201.

Park SC, et al. Effect of adding cervical facet joint injections in a multimodal treatment program for long-standing cervical myofascial pain syndrome with referral pain patterns of cervical facet joint syndrome. J Anesth. 2012;26:738-745.

Pasuhirunnikorn P, et al. Comparative outcome of lidocaine versus bupivacaine for cervical medial branch block in chronic cervical facet arthropathy: a randomized double-blind study. World Neurosurg. 2023 Jul;175:e662-e668.

Riberio DC, et al. Mediators of the effects of exercise and manual therapy for people with knee and hip osteoarthritis: A secondary, exploratory analysis of the MOA trial. Osteoarthr Cartil Open. 2024 Jan 9;6(1):100431. eCollection 2024 Mar.

Savegh FE, et al. Efficacy of steroid and nonsteroid caudal epidural injections for low back pain and sciatica: a prospective, randomized, double-blind clinical trial. Spine. 2009 Jun 15;34(14):1441-7.

Schneider MJ, et al. Comparative clinical effectiveness of nonsurgical treatment methods in patients with lumbar spinal stenosis: a randomized clinical trial. JAMA Netw Open. 2019 Jan 4;2(1):e186828.

Schuster N, et al. Is this spine pain facetogenic? Addressing diagnostic myths. Pain Med, 2021;22(S1):S31-S35.

Shah RD, et al. Interventional procedures for chronic pain in children and adolescents: a review of the current evidence. World Institute of Pain. 2016:359-369.

Tsertsvadze A, et al. Cost-effectiveness of manual therapy for the management of musculoskeletal conditions: a systematic review and narrative synthesis of evidence from randomized controlled trials. J Manipulative Physiol Ther. 2014; 37(6): 343-62.

Urits I, et al. A comprehensive review of alternative therapies for the management of chronic pain patients: acupuncture, tai chi, osteopathic manipulative medicine, and chiropractic care. Adv Ther. 2020;38(1):76 - 89. Epub 2020 Nov 12.

Wardhana A, et al. Comparison of radiofrequency and corticosteroid injection for treatment of lumbar facet joint pain: a meta-analysis. Asian J Anesthesiol. 2022 Jun 1;60(2).

Yun DH, et al. Efficacy of ultrasonography-guided injections in patients with facet syndrome of the low lumbar spine. Ann Rehabil Med. 2012; 36:66-71

SEARCH TERMS

Not Applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Facet Joint Interventions for Pain Management (LCD L35936) [accessed 2025 May 29]

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid

guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.

- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION	
Committee Approval Dates	
03/20/25, 06/26/25	
Date	**Summary of Changes**
06/26/25	• Annual review, policy intent unchanged.
03/20/25	• New Policy created due to the splitting of policy content of CMP#7.01.87 into CMP#7.01.115 & CMP#7.01.116. No change to original policy criteria.
01/01/25	• Summary of changes tracking implemented.
03/20/25	• Original effective date