MEDICAL POLICY

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Medical Policy Title	**Interventional Pain Management for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members**
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Our medical policies are guides to evaluate technologies or services for medical necessity. Criteria are established through the assessment of evidence based, peer-reviewed scientific literature, and national professional guidelines. Federal and state law(s), regulatory mandates and the member's subscriber contract language are considered first in the determination of a covered service.
(Link to Product Disclaimer)

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POLICY STATEMENT(S)

Initial Epidural Steroid Injection (ESI)

I. An initial ESI (caudal, interlaminar, or transforaminal) is considered **medically appropriate** when **ALL** the following are met:

   A. The individual has a documented diagnosis of **any** of the following:

      1. Degenerative lumbar spondylolisthesis with associated neurological findings or

impairments (e.g., back pain, leg pain, motor weakness);

2. Failed back surgery syndrome (FBSS) or epidural fibrosis; **or**
3. Spinal stenosis (foraminal, central, or disc disease);

B. Pain-related symptoms meet **all** the following:

1. Radicular pain, acute or chronic, with or without motor weakness;
2. Pain causes a functional impairment;
3. A minimum of 6 weeks of conservative management during the previous 6 months failed to improve symptoms, or was not tolerated, and includes **both** of the following:
   a. Non-pharmacologic management with **either**:
      i. Chiropractic care; **or**
      ii. Supervised physical therapy (PT); **and**
   b. Pharmacological management with **either**:
      iii. Medication directed at the underlying disease process; **or**
      iv. Oral analgesics;

C. ESI will be performed under computed tomography (CT) or fluoroscopic guidance.

II. An initial ESI is considered **not medically necessary** for **ANY** of the following contraindications:

A. Allergy or hypersensitivity to any component of the injectate;

B. Active infection – systemic, local infection at the injection site, or within the spine (e.g., discitis/osteomyelitis);

C. Uncontrolled bleeding or clotting disorder;

D. Malignancy involving the planned injection site;

E. Pregnancy;

F. The individual or legally authorized representative refuses the procedure.

<u>Repeat ESI</u>

III. A repeat ESI (caudal, interlaminar, or transforaminal) is considered **medically appropriate** when **ALL** the following are met:

A. Active participation in non-surgical conservative management with chiropractic care or supervised PT, unless intolerance due to pain is documented;

B. Pain or functional impairment persist;

C. Performed for **either** of the following scenarios:

1. For diagnostic injections(s), with/without steroids, when **both** of the following are met:
    a. No more than two (2) injections in total have been performed; **and**
    b. It has been at least 2 weeks between diagnostic injections; **or**
2. For therapeutic injections, when **all** the following are met:
    a. No more than four (4) injections have been performed per year, per spinal region;
    b. It has been at least 10 weeks between therapeutic injections; **and**
    c. The previous injection(s) resulted in a minimum of 50% reduction in pain lasting for a minimum of 10 weeks.

IV. A repeat ESI is considered **not medically necessary** for **ANY** of the following contraindications:

A. Allergy or hypersensitivity to any component of the injectate;
B. Active infection – systemic, local infection at the injection site, or within the spine (e.g., discitis/osteomyelitis)
C. Uncontrolled bleeding or clotting disorder;
D. Malignancy involving the planned injection site;
E. Pregnancy;
F. The individual or legally authorized representative refuses the procedure.

<u>Selective Nerve Root Block (SNRB)</u>

V. A diagnostic selective nerve root block (SNRB) is considered **medically appropriate** when **ALL** the following are met:

A. Performed at one (1) or more spinal levels;
B. Anesthetic injectate only is used;
C. Performed to assist in establishing a diagnosis of radicular pain (e.g., radiculitis, radiculopathy), when there is no known pain diagnosis, and documentation supports **either** of the following:
    1. Clinical findings are suggestive of nerve root pathology; **or**
    2. Performed for preoperative planning;
D. Completed diagnostic evaluation includes **one (1) or more** of the following:
    1. Neurological examination;
    2. Electrodiagnostic testing; **or**
    3. Relevant imaging studies

VI. SNRB is considered **not medically necessary** for **ANY** of the following contraindications:

A. Allergy or hypersensitivity to any component of the injectate;

B. Active infection – systemic, local infection at the injection site, or within the spine (e.g., discitis/osteomyelitis);

C. Uncontrolled bleeding or clotting disorder;

D. Malignancy involving the planned injection site;

E. Pregnancy;

F. The individual or legally authorized representative refuses the procedure.

Initial Facet Joint Injections (FJI) and/or Medial Branch Blocks (MBB)

VII. An initial FJI (cervical, thoracic, or lumbar) or MBB are considered **medically appropriate** when **ALL** the following are met:

A. Pain-related symptoms meet **all** the following:

1. Persistent for a minimum of 12 weeks;
2. Pain causes a functional impairment that limits activities of daily living; **and**
3. Non-radicular (cervical, thoracic, or lumbar);

B. A minimum of 6 weeks of conservative management, unless contraindicated, during the previous 6 months failed or was not tolerated, including **both** of the following:

1. Non-pharmacologic management with **either**:
   a. Chiropractic care; **or**
   b. Supervised physical therapy (PT); **and**
2. Pharmacological management with **either:**
   a. Medication directed at the underlying disease process; **or**
   b. Oral analgesics;

C. The procedure will be performed under computed tomography (CT), fluoroscopic, or ultrasound guidance.

VIII. An initial FJI or MBB is considered **not medically necessary** for **ANY** of the following contraindications

A. Allergy to any component of the injectate;

B. Uncontrolled bleeding or clotting disorder;

C. Active infection;

D. Pregnancy when ultrasound guidance is not available;

E. History of spinal fusion at the same level.

Repeat FJI/MBB

IX. A repeat FJI or MBB are considered **medically appropriate** when **ALL** the following are met

A. Performed at the same level as the initial block;

B. Performed for **either** of the following scenarios:

1. For diagnostic injection(s), when **all** the following are met:

a. No more than two (2) injections per region;

b. A minimum of 70% reduction in pain was a result of the initial injection; **and**

c. A minimum of 6 weeks of conservative management during the previous 6 months failed or was not tolerated, including **both** the following:

i. Non-pharmacologic management with **either**:

a) Chiropractic care; **or**

b) Supervised physical therapy (PT); **and**

ii. Pharmacological management with **either**:

a) Medication directed at the underlying disease process; **or**

b) Oral analgesics;

OR

2. For therapeutic injections, when **all** the following are met

a. No more than three (3) injections per region performed in a 12-month period;

b. The previous injection(s) resulted in a minimum of 50% pain relief lasting for a minimum of 3 months; **and**

c. Active engagement in non-surgical conservative management with chiropractic care or supervised PT, unless intolerance due to pain is documented.

X. A repeat FJI or MBB is considered **not medically necessary** for **ANY** of the following contraindications:

A. Allergy to any component of the injectate;

B. Uncontrolled bleeding or clotting disorder;

C. Active infection;

D. Pregnancy when ultrasound guidance is not available;

E. History of spinal fusion at the same level.

FJI/MBB as an Alternative to Radiofrequency Ablation/Neurotomy

XI. FJI/MBB as an alternative to radiofrequency ablation/neurotomy is considered **medically appropriate** when **ALL** the following are met:

A. Significant pain relief (e.g., greater than 50%) was a result of the initial FJI/MBB;

B. Pain relief lasted a minimum of 12 weeks;

C. When the individual is not a candidate for radiofrequency denervation/ablation due to **any** of the following:

1. Implanted cardiac device (e.g., pacemaker, defibrillator);
2. Prior diagnostic injection positive outcomes support continued injection-based therapy;
3. Continued anticoagulation therapy is required; **or**
4. Young athletes for whom alternative treatment options are preferred based on long-term considerations.

XII. FJI/MBB as an alternative to radiofrequency ablation/neurotomy is considered **not medically necessary** for **ANY** of the following contraindications

A. Allergy to any component of the injectate;

B. Uncontrolled bleeding or clotting disorder;

C. Active infection;

D. Pregnancy when ultrasound guidance is not available;

E. History of spinal fusion at the same level.

<u>Initial Radiofrequency Neurolysis, Paravertebral Facet Joint/Medial Branch</u>

XIII. Initial radiofrequency neurolysis (denervation/ablation) of a paravertebral facet joint or medial branch is considered **medically appropriate** when **ALL** the following are met:

A. There is no evidence from the clinical assessment, diagnostic evaluation, or imaging studies of an alternative pain generator (e.g., central spinal stenosis, foraminal stenosis, disc herniation, fracture, infection, spinal instrumentation, pseudoarthrosis, or neoplastic disease);

B. Pain-related symptoms meet **all** the following:

1. Persistent for a minimum of 3 months;
2. Pain causes a functional impairment; **and**
3. A minimum of 6 weeks of conservative management during the previous 6 months failed or was not tolerated, including **all** the following:

a. Non-pharmacologic management with **either**:

i. Chiropractic care; **or**

ii. Supervised physical therapy (PT); **and**

b. Pharmacological management with **either**:

i. Medication directed at the underlying disease process; **or**

ii. Oral analgesics;

C. Significant reduction in pain or functional improvement for at least the expected duration of the anesthetic utilized resulted following no more than two (2) diagnostic facet joint injections/medial branch blocks;

D. The procedure will be performed under computed tomography (CT), fluoroscopic, or ultrasound guidance.

XIV. Initial radiofrequency neurolysis (denervation/ablation) of a paravertebral facet joint or medial branch is considered **not medically necessary** for **ANY** of the following contraindications

A. Active infection;

B. Coagulopathy;

C. Myopathy, acquired or congenital;

D. Neuromuscular disease, including but not limited to amyotrophic lateral sclerosis (ALS);

E. Pregnancy;

F. Previous spinal fusion at the same level.

Repeat Radiofrequency Neurolysis, Paravertebral Facet Joint/Medial Branch

XV. Repeat radiofrequency joint neurolysis/medial branch (denervation/ablations) is considered **medically appropriate** when **ALL** the following are met

A. No more than two (2) procedures per spinal region during a 12-month period;

B. At least 6 months since the previous denervation/ablation at the same level;

C. Recurrence of pain after previously successful denervation/ablation;

D. Active engagement in non-surgical conservative management with chiropractic care or supervised physical therapy unless intolerance due to pain is documented.

XVI. Repeat radiofrequency joint neurolysis/medial branch (denervation/ablations) is considered **not medically necessary** for **ANY** of the following contraindications

A. Active infection;

B. Coagulopathy;

C. Myopathy, acquired or congenital;

D. Neuromuscular disease, including but not limited to amyotrophic lateral sclerosis (ALS);

E. Pregnancy;

F. Previous spinal fusion at the same level.

Sacroiliac Joint Injection – Diagnostic

XVII. A diagnostic sacroiliac joint injection is considered **medically appropriate** when **ALL** of the following are met:

A. At least one (1) sacroiliac provocative test is positive;

B. Pain-related symptoms meet **all** the following:

1. Unilateral non-radicular pain localized over the sacroiliac joint below the L5 level;
2. Persistent for a minimum of 3 months; **and**
3. A minimum of 6 weeks of conservative management, unless contraindicated, during the previous 6 months failed, including **both** of the following:
   a. Non-pharmacologic management with **either**:
      i. chiropractic care; **or**
      ii. supervised physical therapy (PT); **and**
   b. Pharmacological management includes **either**:
      i. Medication directed at the underlying disease process; or
      ii. Oral analgesics;

C. Injection will be performed under computed tomography (CT) or fluoroscopic guidance.

XVIII. A diagnostic sacroiliac joint injection is considered **not medically necessary** for **ANY** of the following contraindications:

A. Allergy to any component of the injectate

B. Uncontrolled bleeding or clotting disorder

C. Active infection, including systemic or at the injection site;

D. Pregnancy.

Sacroiliac Joint Injection - Therapeutic

XIX. A therapeutic sacroiliac injection for sacroiliac joint pain is considered **medically appropriate** when documentation meets **ALL** the following:

A. A minimum of 50% reduction in pain was a result of the diagnostic injection;

B. Active engagement in non-surgical conservative management with chiropractic care or supervised PT, unless intolerance due to pain is documented;

C. Pain causes a functional impairment.

XX. A therapeutic sacroiliac injection for sacroiliac joint pain is considered **not medically necessary**

for **ANY** of the following contraindications

A. Allergy to any component of the injectate;

B. Uncontrolled bleeding or clotting disorder;

C. Active infection, including systemic or at the injection site;

D. Pregnancy.

Sacroiliac Joint Injection - Repeat

XXI. Repeat sacroiliac injection(s) are considered **medically appropriate** when documentation meets **ALL** the following:

A. Active engagement in non-surgical conservative management with chiropractic care or supervised PT, unless intolerance due to pain is documented;

B. Injection(s) will be performed under computed tomography (CT) or fluoroscopic guidance;

C. Performed for **either** of the following scenarios:

1. For diagnostic injections(s) when **both** the following are met:
    a. No more than two (2) injections per region; **and**
    b. A minimum of 75% reduction in pain resulting from the initial injection; **or**
2. For therapeutic injections, when **all** the following are met:
    a. No more than four (4) injections per region performed in a 12-month period;
    b. A minimum of 50% pain relief from the initial injection;
    c. Pain relief lasted for a minimum of two (2) months; **and**
    d. Active engagement in non-surgical conservative management with chiropractic care or supervised PT, unless intolerance due to pain is documented.

XXII. Repeat sacroiliac injection(s) are considered **not medically necessary** for **ANY** of the following contraindications:

A. Allergy to any component of the injectate

B. Uncontrolled bleeding or clotting disorder

C. Active infection, including systemic or at the injection site;

D. Pregnancy.

RELATED POLICIES

Corporate Medical Policy

7.01.124 Intraosseous Basivertebral Nerve Ablation for Child Health Plus (CHP) and Essential Plan (EP) Members

7.01.126 Spine Procedures for Managed Medicaid (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Essential Plan (EP) Members

POLICY GUIDELINE(S)

I. If an individual demonstrates improvement during the initial 6 weeks of PT, an additional 6 weeks of PT should be attempted prior to interventional pain management.

II. Relative contraindications to ESI (caudal, interlaminar, transforminal) include **any** of the following:

A. Acute spinal cord compression;

B. Cauda equina syndrome or myelopathy;

C. Chronic immunosuppression;

D. Uncontrolled medical comorbidity(ies);

E. Clinical improvement to conservative management; **or**

F. For interlaminar ESI only: severe spinal stenosis.

DESCRIPTION

Interventional pain management encompasses a group of image-guided, minimally invasive procedures used to diagnose and treat spinal and sacroiliac pain that has not responded adequately to conservative care (with the exception of urgent or emergent conditions [e.g., cauda equina syndrome]). These procedures are generally considered when pain persists despite an appropriate trial of non-pharmacologic management (such as supervised physical therapy or chiropractic care) and pharmacologic management, and when pain results in functional impairment that limits activities of daily living. They are intended to be used selectively as part of a broader, multimodal treatment plan rather than as stand-alone or indefinitely repeated therapy and are typically performed under image guidance (fluoroscopy, computed tomography [CT], or, where appropriate, ultrasound) to improve accuracy and safety.

Urgent and emergent conditions should be excluded prior to consideration of an elective interventional pain procedure. Features suggesting cauda equina syndrome (such as new bowel or bladder dysfunction, saddle sensory loss, or progressive bilateral or multilevel lower-extremity weakness), acute spinal cord compression, or myelopathy represent neurologic emergencies that warrant prompt advanced imaging and surgical evaluation rather than interventional pain treatment. Likewise, findings that raise concern for infection, malignancy, or fracture require further diagnostic evaluation before proceeding.

Identification of the underlying pain generator and type of pain helps guide selection of the appropriate intervention. Radicular pain arises from irritation or compression of a spinal nerve root and typically radiates into an extremity in a nerve root distribution, often with sensory changes and sometimes with motor deficits or reflex loss (radiculopathy). Radicular pain is the principal target of

epidural steroid injections (ESI) and selective nerve root blocks (SNRB). Axial, non-radicular pain is localized to the spine or adjacent regions without radiation along a nerve root and generally lacks objective neurologic findings of radiculopathy. Facet joint and sacroiliac joint procedures are the principal interventions used to evaluate and treat this type of pain.

Interventions

Epidural steroid injections (ESI) deliver anti-inflammatory corticosteroid medication, with or without local anesthetic, into the epidural space surrounding a spinal nerve root. Three approaches are used: a transforaminal approach (TFESI), which enters through the neural foramen; an interlaminar approach (ILESI), which passes between adjacent laminae; and a caudal approach (CESI), which enters through the sacral hiatus. Contrast material is typically introduced, when not contraindicated, to confirm needle placement under imaging guidance. ESIs are most commonly used for radicular pain (arising from irritation or compression of a spinal nerve root; radiculopathy or radiculitis) and related symptoms associated with conditions such as disc herniation, spinal stenosis, degenerative spondylolisthesis, and post-surgical epidural fibrosis (scar tissue adjacent to a nerve root, most often following spinal surgery). ESIs are primarily aimed at short-term relief of pain and improvement in function, which may facilitate participation in rehabilitation.

Selective nerve root blocks (SNRB) involve administration of local anesthetic at a specific nerve root and are used primarily as a diagnostic tool. By determining whether anesthetizing a particular nerve root relieves pain, an SNRB may help identify the symptomatic level when the clinical presentation, imaging findings, and electrodiagnostic studies are inconclusive and may assist in preoperative planning.

Facet joint injections (FJI) and medial branch blocks (MBB) target the paravertebral (zygapophyseal) joints or the medial branch nerves that innervate them, and are used for non-radicular, axial spinal pain of suspected facet origin. These interventions may be performed diagnostically, to confirm the facet joints as the source of pain, or therapeutically. A favorable, well-documented response to diagnostic blocks is generally used to select patients who are likely to benefit from subsequent radiofrequency treatment.

Radiofrequency neurotomy (also referred to as denervation, ablation, or radiofrequency ablation [RFA]) applies thermal energy to interrupt the medial branch nerves supplying a facet joint and may provide longer-lasting pain relief than injections alone in appropriately selected patients. It is typically reserved for individuals who have demonstrated a meaningful but temporary response to diagnostic facet joint injections or medial branch blocks and in whom no alternative pain generator has been identified through clinical and imaging evaluation.

Sacroiliac joint (SIJ) injections are used to evaluate and treat unilateral, non-radicular pain localized below the L5 level. Diagnostic (prognostic) blocks are used to confirm the joint as the pain generator, typically in conjunction with positive provocative testing (e.g., distraction, compression, thigh thrust, sacral thrust, Gaenslen's, and FABER/Patrick tests). Therapeutic injections are reserved for patients who have a meaningful, documented response to a diagnostic block.

SUPPORTIVE LITERATURE

Epidural Steroid Injection (ESI)

ESI is one of several options for individuals who fail conservative treatment, and is a common modality used for radicular pain and lumbar referred pain associated with degenerative or isthmic conditions (e.g., disc herniation, spinal stenosis, degenerative spondylolisthesis, and post-surgical epidural fibrosis). Overall, the evidence indicates that ESI provides modest, primarily short-term improvement in radicular pain and function, with limited evidence of durable benefit or reduction in the need for surgery. Outcomes appear most favorable for disc-herniation radicular pain, less consistent for spinal stenosis and cervical radiculopathy, and insufficient for failed back surgery syndrome. ESI is therefore best used selectively to provide short-term symptom relief and facilitate participation in rehabilitation rather than as a stand-alone or indefinitely repeated therapy.

Armon et al (2025) published a systematic review summary report of the American Academy of Neurology (AAN) Guidelines Subcommittee evaluating the efficacy of ESIs for cervical and lumbar radicular pain and spinal stenosis. Based on 90 RCT, ESIs probably reduced short-term pain and disability in cervical and lumbar radiculopathies and possibly reduced disability in lumbar spinal stenosis. Evidence was insufficient to determine whether ESIs reduce long-term pain. The review affirms limited efficacy of ESIs in reducing pain and disability, with benefits largely in the short term.

ESI - Lumbar

In a Cochrane review, Oliveira et al (2020) conducted a systematic review and meta-analysis of 25 placebo-controlled randomized trials (n=2,470) evaluating epidural corticosteroid injections for lumbosacral radicular pain. Moderate-quality evidence indicated that injections were slightly more effective than placebo for short-term leg pain and short-term disability, but the treatment effects were small and may not be clinically important (mean difference lower than 10%). No benefit over placebo was seen for leg pain at intermediate- or long-term follow-up, and adverse events were mostly minor. The authors concluded that the evidence provides only limited support for ESI in lumbosacral radicular pain, with benefits small and largely confined to the short term.

Verheijen et al (2021) conducted a meta-analysis of 17 randomized controlled trials (RCT) comparing ESI with epidural or nonepidural placebo in patients with sciatica. Compared with epidural placebo, ESI was not significantly more effective for back pain at 6 weeks, 3 months, or 6 months; leg pain was significantly improved at 6 weeks and 3 months but not at 6 months; and functional status was improved at 6 weeks only. Compared with nonepidural placebo, ESI did not significantly improve leg pain or function at any time point. The quality of evidence ranged from very low to moderate across outcomes. The authors concluded that ESI may provide modest short-term benefit for some patients with sciatica but that evidence supporting durable improvement is limited. Review limitations included heterogeneity among studies, variable definitions of treatment success, relatively small numbers of studies for several outcome analyses, uncertain clinical significance of some reported effects, and limited characterization of patient populations, making it difficult to identify subgroups most likely to benefit.

Wilby et al (2021) reported the NERVES trial, a multicenter, open-label RCT comparing transforaminal epidural steroid injection (TFESI) with surgical microdiscectomy in 163 patients with sciatica secondary to a herniated lumbar disc unresponsive to conservative care. The primary outcome, Oswestry disability at 18 weeks, did not differ significantly between groups, and both treatments improved disability and leg pain through follow-up. Microdiscectomy produced modestly greater improvement on some measures but was associated with more serious adverse events and higher cost, with an incremental cost-effectiveness ratio above the accepted threshold. The authors concluded that TFESI is a reasonable, less invasive, and less costly initial option prior to microdiscectomy in appropriately selected patients.

Wang and Zhang (2025) conducted a systematic review and meta-analysis of 7 studies (4 RCTs and 3 prospective studies; n=416) comparing epidural PRP versus corticosteroid injection for lumbar radicular pain. Corticosteroids significantly reduced Oswestry Disability Index (ODI) scores at 4 weeks ($p = 0.0008$), with no significant differences in VAS or ODI scores between groups at other time points. Complication rates were similar, though incomplete reporting may underestimate risks. The authors concluded that PRP did not demonstrate superior improvements over corticosteroid injections for lumbar radicular pain, while corticosteroids showed significant short-term functional improvement. The review was limited by low study quality and heterogeneity in PRP preparation methods.

ESI – Lumbar Spinal Stenosis

Schneider et al (2019) published the results of a 3-arm RCT comparing the clinical effectiveness of medical care (n=88), group exercise (n=84), and manual therapy/individualized exercise (n=87) in patients with lumbar spinal stenosis. Treatment in the medical care group consisted of medications and/or ESI provided by a physiatrist. Study limitations include failure to disclose the proportion of patients in the medical care group that received ESI during the course of the study, excluding patients <60 years of age, and no direct reporting of pain outcomes. The primary outcomes were symptoms and physical function as measured by the patient-reported Swiss Spinal Stenosis (SSS) score. The SSS score ranges from 12 to 55 points, with higher scores indicating higher levels of self-reported disability. Analyses at 2 months indicated that manual therapy/individualized exercise demonstrated greater reduction in SSS score compared to medical care or group exercise. The magnitude of the difference in the reduction of SSS score between groups did not reach the level of a minimal clinically important difference of 3.02 points.

ESI - Failed Back Surgery Syndrome

Epidural steroid injections have been studied specifically in patients with persistent back and radicular symptoms following lumbar surgery (failed back surgery syndrome, also termed persistent spinal pain syndrome or post-laminectomy syndrome), most often related to epidural fibrosis.

Manchikanti et al (2012) reported a randomized, double-blind, active-control trial of fluoroscopically guided caudal epidural injections in 140 patients with post-lumbar surgery syndrome, comparing local anesthetic alone with local anesthetic plus non-particulate steroid and following patients for 24 months. Significant improvement in pain and function was sustained in approximately 53% to 59% of patients at 12 months and 47% to 58% at 24 months, with responders averaging roughly 62 to 68

weeks of relief over the 2-year period and no meaningful difference between the anesthetic-only and steroid groups. The authors concluded that caudal epidural injections, with or without steroids, can provide durable relief in this population.

Celenlioglu et al (2022) compared caudal (CESI) and transforaminal (TFESI) epidural steroid injection in 56 patients with post lumbar surgery syndrome (PLSS) in a prospective, randomized, assessor-blind study(n = 26 CESI group; n = 30 TFESI group). Treatment success was defined as a ≥ 50% decrease in the Numeric Rating Scale (NRS-11) scores compared to baseline. NRS-11 and modified Oswestry Disability Index (mODI) scores improved significantly in both groups at all follow-ups, with greater early disability improvement in the TFESI group at 3 weeks; both approaches were effective and safe. The study was limited by the lack of a placebo-controlled group and a short follow-up period.

ESI - Cervical

Cohen et al (2014) reported the results of an RCT that compared ESI, conservative treatment, and a combination of both for patients with cervical radiculopathy. A total of 169 patients were randomized to conservative care (physical therapy plus medications), ESIs, or a combination of both treatments. The primary outcomes were neck and arm pain measured at 1- and 3- months posttreatment. There were no differences noted between ESI and conservative care on any of the outcome measures. The group receiving combination therapy had a greater reduction in arm pain at 1 month compared with the two individual treatments and had a greater success rate at 3 months (56.9% vs. 26.8%, p=.006).

Borton et al (2022) performed a systematic review of cervical transforaminal ESIs for cervical radiculopathy. The review included six studies (3 RCTs and 3 observational studies; n=443). None of the included studies directly compared cervical transforaminal ESIs with other treatment options or placebo. Short-term (4 to 8 weeks) decreases in pain scores following injections varied greatly both within and between the six studies, and mean reduction in pain scores ranged from 18% to 70%. Four studies reported on longer-term pain relief (> 8 weeks), and mean reduction in pain scores ranged from 33% to 73%; however, there was a significant number of patients lost to follow-up in these studies.

ESI – Technique and Safety

Ahmed et al (2023) performed a meta-analysis of seven randomized controlled trials comparing ultrasonography (USG)-guided versus conventional fluoroscopy (FL)-guided ESIs for radiculopathy. There was no statistically significant difference in pain reduction between groups at the lumbosacral level at 1 month or 3 months. Functional improvement was also comparable between groups. USG guidance was associated with a significantly lower risk of inadvertent vascular puncture (OR 0.21; 95% CI 0.07–0.64) and shorter procedure time compared to FL guidance. There was no significant difference in the need for repeat ESIs between groups. Study limitations include heterogeneity due to inclusion of both cervical and lumbosacral levels, different epidural approaches, and different steroids used. The authors concluded that USG-guided ESIs are noninferior to FL-guided ESIs in terms of pain reduction and functional improvement.

Kimura et al (2023) conducted a systematic review and meta-analysis of 8 RCTs (n=962) to compare US-guided versus FL- or CT-guided spinal nerve injections. There was little to no difference in pain reduction or functional disability between groups. US guidance probably reduced major adverse events (0.7% vs 6.5%) and minor adverse events (2.1% vs 4.2%), and significantly reduced procedure time (MD −4.19 min; 95% CI −5.09 to −3.30). The authors concluded that US-guided injections remained effective while reducing adverse events compared to conventional guidance.

Armon et al (2025) reported that the systematic review of 90 RCT did not identify studies addressing the efficacy of repeated ESIs, despite noting that ESIs are not infrequently used repeatedly every few months in clinical practice. The authors stated that repeated ESIs are associated with adverse effects caused by long-term corticosteroid use that can outlast discontinuation of treatment. Epidural lipomatosis has been described after repeated ESIs and may worsen spinal stenosis. Repeated ESIs were considered potentially useful when continued short-term effectiveness is likely based on previous responsiveness to ESIs and when alternative interventions are not effective, are contraindicated, or are inconsistent with patient preferences, with close monitoring for ongoing effectiveness necessary to justify continuing treatment. The authors further noted that the small effect size and modest clinical efficacy for short-term pain and disability reduction should be considered in patient selection and that factors such as older age, obesity, anticoagulation use, and inability to participate in physical therapy because of comorbid conditions may influence ESI use. Reported complication rates ranged from 2.4% to 16.8%, and the review cited the 2014 FDA warning that epidural corticosteroid injection may result in rare but serious adverse events, including loss of vision, stroke, paralysis, and death. Evidence was insufficient to determine whether particulate epidural steroid injections are more effective than nonparticulate preparations.

Selective Nerve Root Block (SNRB) - Diagnostic

Riew et al (2006) reported a minimum five-year follow-up of a prospective, randomized, double-blind study of nerve root blocks in operative candidates with lumbar radicular pain who had initially requested surgery. Among patients who avoided an operation in the original study, 17 of 21 reassessed at five years still had not undergone surgery, with no difference between bupivacaine alone and bupivacaine plus betamethasone and sustained improvement in neurologic symptoms and back pain. The authors concluded that most patients who avoid surgery for at least one year after a nerve root block continue to avoid it for at least five years.

Beynon et al (2019) conducted a systematic review of six studies evaluating the diagnostic accuracy of SNRB in patients with lumbar radiculopathy and equivocal or discordant clinical and imaging findings. All included studies were judged to be at high risk of bias. Pooled estimates from cohort studies showed high sensitivity but low specificity (90.9% and 22.0%, respectively, when outcome following surgery was the reference standard), with positive likelihood ratios generally low (<5), indicating that a positive SNRB did not substantially increase the probability that the nerve root was the pain source. The authors concluded that the evidence was limited and that the diagnostic accuracy of SNRB could not be determined with confidence. They further noted that it remains unclear whether the diagnostic information provided by SNRB improves surgical decision-making or patient outcomes.

SNRB - Therapeutic

Kanaan et al (2020) conducted a prospective study of fluoroscopically guided therapeutic SNRB in 76 patients with lumbar radiculopathy secondary to disc prolapse or foraminal stenosis. Immediate improvement was reported in 90.7% of patients; however, 61.8% experienced recurrent pain during follow-up. Study limitations included the small sample size, inclusion of patients with both disc prolapse and foraminal stenosis without separate analyses by underlying pathology, and limited follow-up duration, restricting assessment of long-term outcomes. The authors reported avoidance of surgery in up to 54% of patients and pain relief lasting at least 6 months in up to 29% following a single SNRB, supporting its use as a second-line treatment option after conservative management.

SNRB - Frequency and Safety

Karlsson et al (2024) conducted a prospective observational cohort study using the PROMIS-29 in 103 patients undergoing fluoroscopically guided SNRB for lumbar radicular pain from disc herniation or spinal stenosis. Patient-reported outcome measures (PROMs) were assessed with the PROMIS-29 for 12 weeks (84 days) following the SNRB. Patients were stratified based on their pain reduction at the 14-day follow up as responders (≥ 30% pain reduction) and non-responders (< 30% pain reduction). Only 44% (n=45) of the patients were responders and showed significant improvement in all parameters throughout the 84-days follow-up, the exception was sleep that lost significance at day 70. The mean post-treatment duration among responders was 59 (52–67) days. Non-responders showed significant improvements in pain interference and pain intensity until day 35 and in ability for social participation until 21-day. The authors concluded that SNRB can improve pain intensity, pain interference, physical function, fatigue, anxiety, depression, sleep disturbance, and the ability to participate in social roles

Welinder et al (2025) performed a scoping review of complications associated with transforaminal or foraminal lumbar SNRB in adults with degenerative spine conditions. A total of 118 studies were included, comprising 15,817 patients and 72,518 procedures. Overall, 4,439 complications representing 145 distinct complication types were identified. Of these, 5.2% were classified as mild or moderate and 0.2% as severe according to the CTCAE grading system. The adjusted overall complication rate was 5.4% per procedure and 5.8% per patient. The most frequently reported complications were intravascular injection, vasovagal reactions, and central steroid effects, while severe complications, including infection and paralysis, were rare (≤0.03%). Lumbar SNRB was associated with a low complication rate, and serious complications were rare. The study was limited by heterogeneity, inconsistent complication reporting, and missing data, which may have introduced bias and reduced the precision of the estimates.

Facet Joint Injection / Medial Branch Block

Manchikanti et al (2015) conducted a systematic review that included three double-blind RCTs (n=340 total) by the same investigator group, comparing therapeutic medial branch blocks with bupivacaine alone versus bupivacaine with steroid (betamethasone) in patients with facet joint pain (cervical, thoracic, lumbar) confirmed by ≥80% pain reduction following two diagnostic medial branch blocks. Significant pain relief with at least 50% improvement in disability scores was reported

in all studies for at least 24 months. However, these studies lacked placebo or sham control groups, and the findings have not been replicated by independent investigators.

Cohen et al (2018) conducted the Facet Treatment Study (FACTS), a multicenter RCT in which 229 participants with chronic axial low back pain were randomized to intra-articular facet injections, medial branch blocks, or saline injections, with the dual aims of assessing whether the blocks were therapeutic and whether a positive diagnostic block predicts outcomes after radiofrequency ablation. At 1 month, mean reduction in average pain scores was 0.7 points in all three groups (P=0.993), and only 12%, 11%, and 6% of participants, respectively, achieved a positive clinical outcome, indicating the blocks themselves were not therapeutic.

Manchikanti et al (2024) conducted a systematic review and meta-analysis to evaluate the effectiveness of facet joint nerve blocks as a therapeutic modality in managing chronic axial spinal pain of facet joint origin. 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). Based on 9 RCTs and 12 non-randomized studies, the authors graded the evidence as Level II with a moderate-to-strong recommendation for therapeutic facet joint nerve blocks in managing spinal facet joint pain. They noted that the overall body of high-quality literature remains limited, and that much of the supporting RCT evidence derives from a single investigator group without broad independent replication.

Radiofrequency Neurolysis (Denervation/Ablation)

Juch et al (2017) reported the Multidisciplinary Interventional Neurosurgical Treatment (MINT) randomized clinical trials, which evaluated radiofrequency denervation combined with a standardized exercise program versus a standardized exercise program alone in patients with chronic low back pain attributed to the facet joints, sacroiliac joints, or a combination of facet joints, sacroiliac joints, and intervertebral discs. The multicenter trials included 681 participants enrolled from 16 pain clinics in the Netherlands, with follow-up through 12 months. All participants received a 3-month exercise program, and those assigned to intervention received radiofrequency denervation in addition to exercise. The primary endpoint was pain intensity at 3 months. Across the three trials, radiofrequency denervation resulted in either no improvement or no clinically important improvement in chronic low back pain compared with exercise alone. The authors noted several limitations, including the absence of blinding, use of different denervation techniques in the sacroiliac joint trial, uncertainty regarding optimal diagnostic block thresholds, and crossover to radiofrequency denervation among some control participants during longer-term follow-up.

Cohen et al (2018), in the same FACTS RCT described under Facet Joint Injection/Medial Branch Block, also assessed whether a positive diagnostic block predicts outcomes after radiofrequency ablation. Positive diagnostic block responses occurred more frequently in the intra-articular injection (54%) and medial branch block (55%) groups than in the saline group (30%; P=0.01). A total of 135 participants subsequently underwent radiofrequency ablation; during the 3 months following ablation, positive outcomes were reported in 51% of the intra-articular group, 56% of the medial branch block group, and 24% of the placebo group (P=0.005). The strongest predictor of a positive ablation

outcome was a positive diagnostic block, which increased the odds of a positive outcome 6.87-fold (P<0.001). Follow-up extended to 6 months after ablation. The authors concluded that facet blocks were not therapeutic but may provide prognostic value before radiofrequency ablation.

Van Eerd et al (2021) conducted a multicenter, double-blind, randomized sham-controlled trial evaluating radiofrequency denervation in 76 patients with chronic cervical facet joint pain diagnosed clinically without diagnostic block confirmation. Patients received radiofrequency denervation combined with bupivacaine or bupivacaine alone. At the 6-month primary endpoint, no significant differences were observed between groups, with greater than 30% pain reduction reported by 55.6% of the radiofrequency group and 51.3% of the control group (P=0.711). No significant differences were identified in Patient Global Impression of Change scores, Neck Disability Index scores, or medication use. Although no significant between-group differences were observed for the primary outcome, the median duration of treatment success was longer in the radiofrequency group than in the control group (42 months versus 12 months; P=0.014). The authors concluded that radiofrequency denervation did not improve the primary outcome compared with the control intervention in patients selected without prior diagnostic block confirmation, although a longer duration of treatment success was observed in the radiofrequency group.

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.

Manchikanti et al (2026) conducted a systematic review and meta-analysis of 17 RCT (12 were active-controlled and 5 were placebo/sham-controlled) evaluating RFA for chronic axial spinal pain of facet joint origin. The review identified statistically significant improvements in pain outcomes at 6 and 12 months and found that outcomes were generally most favorable in studies utilizing diagnostic facet or medial branch blocks for patient selection. Based on qualitative and quantitative analyses, the authors concluded that RFA is an effective treatment option for appropriately selected patients with facet-mediated spinal pain, with Level II evidence, moderate certainty, and a moderate strength of recommendation supporting RFA as an effective option within a multimodal strategy for managing chronic axial spinal pain of facet joint origin. Limitations included study heterogeneity and the relative paucity of uniformly high-quality trials.

Sacroiliac Joint (SIJ) Injection

Overall, the evidence indicates that intra-articular corticosteroid injection provides short-term relief in appropriately selected patients, that no single physical examination maneuver is diagnostic, and that a cluster of positive provocation tests is more useful for excluding than for confirming SIJ pain. Image guidance (fluoroscopy or CT) is standard to ensure accurate needle placement.

Patel et al (2023) conducted a single-blind randomized controlled trial of fluoroscopy-guided intra-articular sacroiliac joint injection in 72 patients with sacroiliac joint dysfunction diagnosed by IASP criteria (pain localized over the joint below L5). Patients were randomized to corticosteroid (triamcinolone) plus 2% lignocaine (group A) or distilled water plus 2% lignocaine (group B), with pain (NPRS) and disability (ODI) assessed at 2 and 4 weeks. Both outcomes improved significantly from baseline in each group, but group A showed significantly greater improvement at both timepoints (NPRS $p<0.001$; ODI $p=0.009$ at 2 weeks, $p<0.001$ at 4 weeks). The authors concluded that fluoroscopy-guided corticosteroid injection effectively reduced pain and disability for up to one month of follow-up, while noting limited long-term evidence and the single-blind design and small sample size as limitations.

Park et al (2026) conducted a systematic review and network meta-analysis of interventional treatments for SIJ pain, including 18 RCT (n=1075) comparing conventional, cooled, and pulsed radiofrequency ablation, intra-articular steroid injections under different imaging guidance, prolotherapy, platelet-rich plasma, sham, and conservative management. Primary outcomes were pain intensity and ODI at 1, 3, and 6 months. CT-guided intra-articular steroid injection ranked highest for disability improvement at 6 months, while radiofrequency-based interventions consistently outperformed steroid injections, sham, and conservative care for pain relief. The certainty of evidence was graded low to very low due to imprecision and study limitations. This analysis supports image-guided (CT or fluoroscopic) intra-articular steroid injection as a therapeutic option while establishing that durable relief favors neuroablation.

Sacroiliac Joint (SIJ) Ablation

Janapala et al (2024) conducted a meta-analysis on the effectiveness of RFA for SIJ pain. The review included 8 RCTs and 12 observational studies meeting inclusion criteria. Qualitative analysis, after downgrading based on GRADE criteria, resulted in Level III evidence with fair recommendation for RFA in managing sacroiliac joint pain. The meta-analysis included both dual-arm and single-arm analyses. A single-arm meta-analysis of 12 studies (including both RCTs and observational studies) showed a mean pain score reduction of 3.848 points at 3 months follow-up ($p<.0001$). Dual-arm analysis comparing RFA to non-active controls at 3 months showed a statistically significant difference in pain levels ($p=.02$). Functional improvement was variable but generally showed significant improvement across different time points. The authors suggest that while the evidence supports a Level III recommendation for RFA in managing sacroiliac joint pain, further high-quality research is needed to strengthen these findings.

Sacral Lateral Branch Radiofrequency Ablation

Cohen et al (2024) conducted a multicenter, randomized comparative-effectiveness trial in 210

patients with clinically suspected sacroiliac joint pain who experienced short-term benefit from a diagnostic intra-articular sacroiliac joint (SIJ) injection and responded to prognostic lateral branch blocks. Patients were randomized to cooled radiofrequency ablation (RFA) of the L5 dorsal ramus and S1-S3 lateral branches or standard medical management (pharmacotherapy, injections, and integrative therapies). At 3 months, mean pain reduction was significantly greater in the RFA group, and 52.3% of RFA-treated patients met responder criteria compared with 4.3% of patients receiving standard medical management. Significant improvements in disability and quality of life were also observed in the RFA group. The authors concluded that cooled RFA provided clinically meaningful improvements in pain, function, and quality of life compared with standard medical management. Limitations included the inability to blind participants and treating physicians and the relatively short duration of comparative follow-up.

Cohen et al (2026) reported 12-month follow-up from the observational extension of the multicenter, randomized comparative-effectiveness trial, in which patients with unsatisfactory outcomes following standard medical management were permitted to cross over to cooled RFA. At 12 months, 57.4% of patients in the original RFA cohort and 55.6% of crossover patients met responder criteria, with sustained improvements in pain, disability, and quality of life following a single treatment. No serious procedure-related adverse events were reported. The authors concluded that cooled RFA provided durable clinical benefit through 12 months in appropriately selected patients. Limitations included observational extension design, attrition during follow-up, and the absence of a long-term control group after crossover.

PROFESSIONAL GUIDELINE(S)

Epidural Steroid Injection (ESI)

The 2021 American Society of Interventional Pain Physicians (ASIPP) guideline on epidural injections in chronic spinal pain (Manchikanti 2021) made the following recommendations:

- Disc herniation: Level I evidence with strong recommendation for caudal epidural injections, lumbar interlaminar epidural injections, lumbar transforaminal epidural injections, and cervical interlaminar epidural injections for long-term effectiveness.
- Spinal stenosis: Level II–III evidence with moderate-to-strong recommendation for caudal and interlaminar approaches; Level III–IV with moderate recommendation for lumbar transforaminal injections.
- Axial discogenic pain (without facet joint pain or sacroiliac joint pain) Level II evidence with moderate to strong recommendation for caudal and interlaminar injections.

The 2022 American Society of Pain and Neuroscience (ASPN) guideline (Sayed 2022) provides recommendations for the use of epidural steroid injections in the treatment of low back pain. Grade A consensus recommendations include:

- Interlaminar epidural injections for treatment of low back and radicular pain originating from disc disease, spinal stenosis and for chronic back/leg pain after surgical intervention.

- Transforaminal epidural injections for treatment of low back and radicular pain originating from disc disease, spinal stenosis and for chronic back/leg pain after surgical intervention.
- Caudal epidural injections for treatment of low back and radicular pain originating from disc disease, spinal stenosis and for chronic back/leg pain after surgical intervention when interlaminar or transforaminal approaches are not feasible
- Use of either steroid or local anesthetic or the two classes of medication in combination for use in epidural injections for treatment of low back and radicular pain originating from disc disease, spinal stenosis and for chronic back/leg pain after surgical intervention.

In 2022, ASPN issued updated consensus guidance on best practices for minimally invasive lumbar spinal stenosis treatment (MIST 2.0) (Deer 2022). The guideline makes the following graded recommendations for epidural steroid injections in symptomatic lumbar spinal stenosis:.

- Epidural steroid injections are recommended within the algorithm for the treatment of symptomatic lumbar spinal stenosis. Grade B; Level of certainty high; Level of evidence I-A)
- Epidural steroid injections may be repeated when a patient experiences significant temporary improvement in symptoms.

Facet Joint Interventions / Medial Branch Block

The 2020 American Society of Interventional Pain Physicians (ASIPP) guideline on facet joint interventions for management of chronic spinal pain (Manchikanti 2020) recommends:

- Diagnostic facet joint nerve blocks using a criterion standard of ≥80% pain relief with dual comparative blocks. Moderate-to-strong strength for lumbar (Level I–II) and moderate strength for cervical and thoracic (Level II).
- Therapeutic facet joint nerve blocks. Moderate strength for lumbar and cervical blocks (Level II) and weak-to-moderate for thoracic blocks (Level III).
- Radiofrequency ablation for treatment is recommended with moderate strength for the lumbar and cervical spine (evidence level II) and weak to moderate strength for the thoracic spine (evidence level III).
- Intra-articular injections received a weak recommendation with lower levels of evidence (level III–V across spinal regions).

The 2020 multispecialty international working group (Cohen 2020) recommends:

- Medial branch blocks as the preferred prognostic test before radiofrequency ablation, being more predictive than intra-articular injections.
- Diagnostic injections, rather than physical exam or imaging, as the reliable means of diagnosing facet-mediated pain.

Radiofrequency Ablation (RFA) - Facet / Medial Branch

The 2020 ASIPP guideline (Manchikanti 2020) recommends medial branch RFA with moderate

strength for the lumbar and cervical spine (Level II) and weak-to-moderate strength for the thoracic spine (Level III), reserved for patients with a confirmed positive response to diagnostic blocks.

The 2020 Consensus practice guidelines on interventions for lumbar facet joint pain from a multispecialty, international working group (Cohen 2020) concluded that more stringent diagnostic-block selection criteria improve denervation outcomes, at the cost of more false-negatives.

Sacroiliac Joint Injection

In 2020, the North American Spine Society (NASS) acknowledged the limited available data and that the optimal procedural technique has not been established. However, based on this limited data, NASS indicates it is reasonable to offer coverage for thermal radiofrequency neurotomy at the L5 dorsal ramus and S1-S3 sacral lateral branches for SIJ pain. NASS does not include recommendation details for other ablative techniques (e.g., pulsed RF, laser, cooled RF, cryoablation).

SIJ Lateral Branch Block / RFA

The 2024 American Society of Pain and Neuroscience (ASPN) Best Practice Guideline for the Treatment of Sacroiliac Disorders (Sayed 2024) recommends:

- RFA of the lateral branches of the S1-S3 dorsal rami along with the L5 dorsal rami (and possibly L4) after an appropriate trial of conservative care and appropriate response to diagnostic blockade.
- Dual diagnostic blockade of the L5 primary dorsal ramus and the S1-S3 sacral lateral branches (± L4 dorsal ramus) with ≥50% improvement in pain and function is the preferred strategy prior to neuroablative procedures.
- Dual (two) blocks are recommended rather than a single block.
- A diagnostic lateral branch block is recommended even if the patient has already had intra-articular SIJ injections, because IA injection does not account for extra-articular pain generators that RFA targets.
- Image guidance (CT or fluoroscopy) is required for the diagnostic blocks and RFA.
- RFA should be performed by an established, researched method and repeated no more than at six-month intervals, and only when ≥50% pain relief with functional improvement has been achieved.

The 2025 American Academy of Pain Medicine (AAPM) and American Society of Regional Anesthesia & Pain Medicine (ASRA-PM) multispecialty consensus practice guidelines on SIJ complex pain (McCormick 2025) found strong evidence that sacral lateral branch RFA provides relief for at least 6 months in extra-articular pathology. The guidelines recommend:

- Targeting the S1-S3 lateral branches in all patients (Grade A, high certainty), with consideration of the L5 dorsal ramus and S4 lateral branch based on individual anatomy (Grade B, moderate certainty).
- Stronger evidence supports larger lesions or more aggressive lesioning strategies over less

stringent techniques.

- A ≥50% positive-block threshold, with three societies dissenting in favor of ≥75% relief from two blocks.
- The evidence for cryoablation was found to be very limited.

Ultrasound Guidance

In 2020, the North American Spine Society (NASS) published coverage policy recommendations for epidural steroid injections & selective spinal nerve blocks which indicates there is insufficient safety and efficacy data to support ultrasound guidance for any approach delivering ESI.

REGULATORY STATUS

The U.S. Food and Drug Administration (FDA) regulates devices and instruments used during interventional pain procedures as medical devices. All devices and instruments including related components require FDA approval before marketing and use in the United States to ensure they are safe and effective for human use. Refer to the FDA Medical Device website. Available from: https://www.fda.gov/medical-devices [accessed 2026 Oct 12]

The FDA lists the most serious type of medical device recalls as well as early alert communications about corrective actions being taken by companies that the FDA believes are likely to be the most serious type of recalls. Available from: https://www.fda.gov/medical-devices/medical-device-safety/medical-device-recalls-and-early-alerts [accessed 2026 Oct 12]

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
Epidural Steroid Injection / Selective Nerve Root Block	
62320	Injection(s), of diagnostic or therapeutic substance(s) (e.g., 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

Code	Description
62321	Injection(s), of diagnostic or therapeutic substance(s) (e.g., 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 (i.e., fluoroscopy or CT)
62322	Injection(s), of diagnostic or therapeutic substance(s) (e.g., 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) (e.g., 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 (i.e., 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
Facet Joint Injections / Medial Branch Blocks	
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
Paravertebral Facet Joint Radiofrequency Neurolysis/Medial Branch Transection	
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

Code	Description
Sacroiliac Joint Injection	
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 (i.e., fluoroscopy or computed tomography)

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HCPCS Codes

Code	Description
Sacroiliac Joint Injection	
G0260	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography
Other Procedures	
Not Applicable	

ICD10 Codes

Code	Description
Multiple codes	

REFERENCES

Epidural Steroid Injection

Ahmed M, et al. Ultrasound-guided versus conventional fluoroscopy-guided epidural injection for radiculopathy. a meta-analysis of randomized controlled trials. World Neurosurg. 2023 Dec;180:203-212.e4.

Akuthota V, et al. The utility of magnetic resonance imaging results in physician decision-making before initial lumbar spinal injection. Spine J. 2019 Sep;19(9):1455-1462.

Armon C, et al. Epidural steroids for cervical and lumbar radicular pain and spinal stenosis systematic review summary: report of the AAN guidelines subcommittee. Neurology. 2025 Mar 11;104(5):e213361.

Bansal A, et al. Current updates in image-guided musculoskeletal interventions. J Clin Orthop Trauma. 2021;22:101601.

Basi HK, et al. Spine injections. In: Steinmetz MP, Berven SH, Benzel EC, editors. Benzel's spine

surgery. 5th ed. Philadelphia (PA): Elsevier; 2022. p. 668-683.e1.

Borton ZM, et al. Cervical transforaminal epidural steroid injections for radicular pain: a systematic review. Bone Joint J. May 2022;104-B(5):567-574.

Celenlioglu AE, et al. Comparison of caudal versus transforaminal epidural steroid injection in post lumbar surgery syndrome after single-level discectomy: a prospective, randomized trial. Pain Physician. 2022 Mar;25(2):161-169.

Cohen SP, et al. Epidural steroid injections, conservative treatment, or combination treatment for cervical radicular pain: a multicenter, randomized, comparative-effectiveness study. Anesthesiology. Nov 2014;121(5):1045-1055.

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.

De Bruijn TM, et al. Clinical relevance of epidural steroid injections on lumbosacral radicular syndrome-related symptoms: systematic review and meta-analysis. Clin J Pain. 2021 Jul 1;37(7):524-537.

Deer TR, et al. Best practices for minimally invasive lumbar spinal stenosis treatment 2.0 (MIST): Consensus guidance from the American Society of Pain and Neuroscience (ASPN). J Pain Res. 2022; 15: 1325-1354

DePalma MJ, et al. Common neck problems. In: Cifu DX, editor. Braddom's physical medicine and rehabilitation. 6th ed. Philadelphia (PA): Elsevier; 2021. p. 627-650.e616

Filippiadis D, et al. Percutaneous imaging-guided techniques for the treatment of benign neuropathic pain. Diagn Interv Imaging. 2021;102(1):11-18.

Fornari M, et al. Conservative treatment and percutaneous pain relief techniques in patients with lumbar spinal stenosis: WFNS Spine Committee recommendations. World Neurosurg X. 2020;7:100079.

Gardocki RJ, et al. Degenerative disorders of the cervical spine. In: Azar FM, Beaty JH, editors. Campbell's operative orthopaedics. 14th ed. Philadelphia (PA): Elsevier; 2021. p. 1682-1718.e5.

Gardocki RJ, et al. Degenerative disorders of the thoracic and lumbar spine. In: Azar FM, Beaty JH, editors. Campbell's operative orthopaedics. 14th ed. Philadelphia (PA): Elsevier; 2021. p. 1719-1801.e9.

International Pain & Spine Interventional Society (IPSIS) [Internet]. Safety practices for interventional pain procedures [accessed 2026 Oct 12]. Available from: https://www.ipsismed.org/page/safetypractices

Jayapaul P, et al. Efficacy of transforaminal epidural steroid injection in patients with lumbar radiculopathy. Interdiscip Neurosurg. 2020;21:100706.

Khalid H, et al. Image-guided cervical injections with most updated techniques and society recommendations. Adv Clin Radiol. 2022;4(1):171-178.

Kimura R, et al. Comparative efficacy of ultrasound guidance and fluoroscopy or computed tomography guidance in spinal nerve injections: a systematic review and meta-analysis. Eur Spine J. 2023 Dec;32(12):4101-4110.

Kose SG, et al. Ultrasound-guided caudal epidural pulsed radiofrequency for the treatment of failed back surgery syndrome: results of a prospective clinical study. Interv Pain Med. 2022;1(4):100145.

Manchikanti L, et al. Epidural injections for lumbar radiculopathy or sciatica: A comparative systematic review and meta-analysis of Cochrane review. Pain Physician. 2021 Aug;24(5):E539-E554.

Manchikanti L, et al. Epidural interventions in the management of chronic spinal pain: American Society of Interventional Pain Physicians (ASIPP) comprehensive evidence-based guidelines. Pain Physician. 2021;24(S1):S27-S208.

Manchikanti L, et al. Fluoroscopic caudal epidural injections in managing post lumbar surgery syndrome: two-year results of a randomized, double-blind, active-control trial. Int J Med Sci. 2012;9(7):582-91.

Nagpal AS, et al. Systematic review of the effectiveness of caudal epidural steroid injections in the treatment of chronic low back or radicular pain. Interv Pain Med. 2022;1(4):100149.

Nelson AM, et al. Interlaminar and transforaminal therapeutic epidural injections. In: Benzon H, editor. Practical management of pain. 6th ed. Philadelphia (PA): Elsevier; 2023. p. 874-891.

North American Spine Society [Internet]. Clinical guidelines. Diagnosis and treatment of low back pain. 2020 [accessed 2026 Oct 12]. Available from: https://www.spine.org/shop?category=11

North American Spine Society [Internet]. Coverage policy recommendations. Epidural steroid injections and selective spinal nerve blocks. Feb 2020. [accessed 2026 Oct 12]. Available from: https://www.spine.org/Coverage

North American Spine Society. Evidence-based clinical guidelines for multidisciplinary spine care: diagnosis and treatment of low back pain. Burr Ridge (IL): North American Spine Society; 2020. Available from: https://www.spine.org/Research/Clinical-Guidelines [accessed 2026 Oct 12]

Oliveira C, et al. Epidural corticosteroid injections for lumbosacral radicular pain. Cochrane database syst rev. 2020 Apr 9;4(4):CD013577.

Reitman CA, et al. Appropriate use criteria for degenerative lumbar spondylolisthesis. Burr Ridge (IL): North American Spine Society; 2020. Available from: https://www.spine.org/Research-Clinical-Care/Quality-Improvement/Appropriate-Use-Criteria [accessed 2026 Oct 12]

Sayed D, et al. The American Society of Pain and Neuroscience (ASPN) evidence-based clinical guideline of interventional treatments for low back pain. J Pain Res. 2022;15:3729-3832.

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.

Verheijen E, et al. Epidural steroid injections are only superior on the short term compared to epidural placebo injections for lumbar radiculopathy. Brain Spine. 2021;1:100187.

Walston Z, et al. Importance of early improvement in the treatment of low back pain with physical therapy. Spine (Phila Pa 1976). 2020;45(8):534-540.

Wang X, et al. Common interventional procedures for chronic non-cancer spine pain: a systematic review and network meta-analysis of randomised trials. BMJ. 2025 Feb 19;388:e079971.

Wang X, Zhang Y. Therapeutic interventions of platelet-rich plasma versus corticosteroid injections for lumbar radicular pain: a systematic review and meta-analysis. J Orthop Surg Res. 2025 Mar 25;20(1):306.

Wilby MJ, et al. Microdiscectomy compared with transforaminal epidural steroid injection for persistent radicular pain caused by prolapsed intervertebral disc: the NERVES RCT. Health Technol Assess. 2021 Apr;25(24):1-86.

Wilby MJ, et al. Surgical microdiscectomy versus transforaminal epidural steroid injection in patients with sciatica secondary to herniated lumbar disc (NERVES): a phase 3, multicentre, open-label, randomized controlled trial and economic evaluation. Lancet Rheumatol. 2021 Mar 18;3(5):e347-e356.

William J, et al. Epidural steroid injections. Phys Med Rehabil Clin N Am. 2022;33(2):215-231.

Selective Nerve Root Block

Beynon R, et al. The utility of diagnostic selective nerve root blocks in the management of patients with lumbar radiculopathy: a systematic review. BMJ Open. 2019 Apr 20;9(4):e025790.

Jang JH, et al. Ultrasound-guided selective nerve root block versus fluoroscopy-guided interlaminar epidural block versus fluoroscopy-guided transforaminal epidural block for the treatment of radicular pain in the lower cervical spine: a retrospective comparative study. Pain Res Manag. 2020 Jun 13;2020:9103421.

Kanaan T, et al. The efficacy of therapeutic selective nerve block in treating lumbar radiculopathy and avoiding surgery. J Pain Res. 2020 Nov 18;13:2971-2978.

Karlsson C, et al. Outcomes after selective nerve root blockade for lumbar radicular pain from lumbar disc hernia or lumbar spinal stenosis assessed by the PROMIS-29 - a prospective observational cohort study. Acta Neurochir (Wien). 2024 Jul 25;166(1):306.

Riew KD, et al. Nerve root blocks in the treatment of lumbar radicular pain. A minimum five-year follow-up. J Bone Joint Surg Am. 2006 Aug;88(8):1722-5.

Viswanathan VK, et al. Role of transforaminal epidural injections or selective nerve root blocks in the management of lumbar radicular syndrome: a narrative, evidence-based review. J Clin Orthop Trauma. 2020;11(5):802-809.

Welinder AF, et al. Complications during lumbar selective nerve root block: a scoping review. Acta Neurochir (Wien). 2025 Dec 20;167(1):329.

Facet Joint Injection / Medial Branch Block

Benzon HT, et al. Multisociety multispecialty consensus recommendations on corticosteroid injections

for facet joint and sacroiliac joint pain. Reg Anesth Pain Med. 2026 Jan 27:rapm-2025-107347. Epub ahead of print.

Bodor M, et al. Ultrasound-guided cervical facet joint injections. Spine J. 2022;22(6):983-992.

Chou R, et al. Interventional treatments for acute and chronic pain: systematic review. Comparative Effectiveness Review No. 247. Rockville (MD): Agency for Healthcare Research and Quality; 2021 Sep. Report No.:21-EHC030.

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;45(6):424-467

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. Erratum in: Anesthesiology. 2018 Sep;129(3):618.

Cohen SP, et al. Facet pain: pathogenesis, diagnosis, and treatment. In: Benzon H, editor. Practical management of pain. 6th ed. Philadelphia (PA): Elsevier; 2023. p. 432-452

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. 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.

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. May 2020;23(3S):S1-S127.

North American Spine Society (NASS) [Internet]. Coverage policy recommendations. Facet joint interventions. 2016 Oct [accessed 2026 Oct 12]. https://www.spine.org/coverage

Sherrier M, et al. Ultrasound basics. In: Williams CJ, Sussman WL, Pitts J, editors. Atlas of interventional orthopedics procedures. Philadelphia (PA): Elsevier; 2023. p. 14-30.

Xu Y, et al. Management of pain by percutaneous anesthetic injections and neurolysis. In: Winn HR, editor. Youmans & Winn neurological surgery. 8th ed. Philadelphia (PA): Elsevier; 2023. p. 1494-1504.e3.

Radiofrequency Neurolysis (Denervation/Ablation)

Chou R, et al. Interventional treatments for acute and chronic pain: systematic review. Comparative Effectiveness Review No. 247. Rockville (MD): Agency for Healthcare Research and Quality; 2021 Sep. Report No.:21-EHC030.

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;45(6):424-467

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. Erratum in: Anesthesiology. 2018 Sep;129(3):618.

Conger A, et al. The effectiveness of radiofrequency ablation of medial branch nerves for chronic lumbar facet joint syndrome in patients selected by guideline-concordant dual comparative medial branch blocks. Pain Med. 2020 May 1;21(5):902-909.

Gill B, et al. Radiofrequency ablation for zygapophyseal joint pain. Phys Med Rehabil Clin N Am. 2022;33(2):233-249.

Janapala RN, et al. Efficacy of radiofrequency neurotomy in chronic low back pain: a systematic review and meta-analysis. J Pain Res. 2021;14:2859-2891.

Juch JNS, et al. Effect of radiofrequency denervation on pain intensity among patients with chronic low back pain: the MINT randomized clinical trials. JAMA. 2017 Jul 4;318(1):68-81. Erratum in: JAMA. 2017 Sep 26;318(12):1188.

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. May 2020;23(3S):S1-S127.

Manchikanti L, et al. Effectiveness of radiofrequency ablation in managing chronic axial spinal pain of facet joint origin: a systematic review and meta-analysis of randomized controlled trials. Pain Physician. 2026 May;29(3):205-240.

North American Spine Society (NASS) [Internet]. Coverage policy recommendations. Facet joint interventions. 2016 Oct [accessed 2026 Oct 12]. https://www.spine.org/coverage

Provenzano DA, et al. Prospective, non-inferiority, multicenter, randomized, single-blind clinical trial comparing cooled radiofrequency ablation to standard radiofrequency ablation to manage chronic facetogenic lumbar back pain. Reg Anesth Pain Med. 2026 Mar 13:rapm-2025-107299.

Schneider BJ, et al. Systematic review of the effectiveness of lumbar medial branch thermal radiofrequency neurotomy, stratified for diagnostic methods and procedural technique. Pain Med. 2020 Jun 1;21(6):1122-1141.

Van Eerd M, et al. Efficacy and long-term effect of radiofrequency denervation in patients with clinically diagnosed cervical facet joint pain: a double-blind randomized controlled trial. Spine (Phila Pa 1976). 2021 Mar;46(5):285-293.

Walsh T, et al. Radiofrequency techniques for chronic pain. BJA Educ. 2022;22(12):474-483.

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).

Sacroiliac Joint Injection and Radiofrequency Ablation

Benzon HT, et al. Multisociety multispecialty consensus recommendations on corticosteroid injections for facet joint and sacroiliac joint pain. Reg Anesth Pain Med. 2026 Jan 27:rapm-2025-107347. Epub ahead of print.

Cohen SP, et al. Cooled radiofrequency ablation provides extended clinical utility in the management

of chronic sacroiliac joint pain: 12-month follow-up results from the observational phase of a randomized, multicenter, comparative-effectiveness crossover study. Reg Anesth Pain Med. 2026 Jun 5;51(6):660-669.

Cohen SP, et al. Cooled radiofrequency ablation versus standard medical management for chronic sacroiliac joint pain: a multicenter, randomized comparative effectiveness study. Reg Anesth Pain Med. 2024 Mar 4;49(3):184-191

Inman RD, et al. Spondyloarthritis. In: Goldman L, Schafer AI, editors. Goldman-Cecil medicine. 27th ed. Philadelphia (PA): Elsevier; 2024. p. 1760-1767.e1.

Janapala RN, et al. Systematic review and meta-analysis of the effectiveness of radiofrequency ablation of the sacroiliac joint. Curr Pain Headache Rep. 2024 May;28(5):335-372.

Ladd B, et al. Sacroiliac joint pain. In: Steinmetz MP, Berven SH, Benzel EC, editors. Benzel's spine surgery. 5th ed. Philadelphia (PA): Elsevier; 2022. p. 1205-1213.e2.

MacVicar J, et al. Appropriate use criteria for fluoroscopically guided diagnostic and therapeutic sacroiliac interventions: results from the Spine Intervention Society convened multispecialty collaborative. Pain Med. 2017;18(11):2081-2095.

McCormick ZL, et al. Consensus practice guidelines on sacroiliac joint complex pain from a multispecialty, international working group. Reg Anesth Pain Med. 2025 Nov 29:rapm-2025-107387. Epub ahead of print.

Newman DP, et al. Sacroiliac joint dysfunction: diagnosis and treatment. Am Fam Physician. 2022;105(3):239-245.

North American Spine Society (NASS) [Internet]. Coverage policy recommendations. Sacroiliac joint injections and radiofrequency ablation. 2020 Oct [accessed 2026 Oct 12]. https://www.spine.org/coverage

Park JH, et al. Interventional treatments for sacroiliac joint pain: a systematic review and network meta-analysis. Reg Anesth Pain Med. 2026 Mar 30:rapm-2026-107633.

Patel A, et al. Effect of fluoroscopic-guided corticosteroid injection in patients with sacroiliac joint dysfunction. Cureus. 2023 Mar 20;15(3):e36406.

Sayed D, et al. American Society of Pain and Neuroscience best practice (ASPN) guideline for the treatment of sacroiliac disorders. J Pain Res. 2024 May 3;17:1601-1638.

Soar H, et al. Lumbar radicular pain. BJA Educ. 2022;22(9):343-349.

Yang AJ, et al. Radiofrequency ablation for the posterior sacroiliac joint complex pain: a narrative review. PMR. 2019;1 (Suppl 1): S105-S113.

Yang AJ, et al. Sacroiliac joint interventions. Phys Med Rehabil Clin N Am. 2022;33(2):251-265.

SEARCH TERMS

Not Applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Facet Joint Interventions for Pain Management (LCD L35936) [accessed 2026 Oct 12]

Epidural Steroid Injections for Pain Management (LCD L39036) [accessed 2026 Oct 12]

Sacroiliac Joint Injections and Procedures (LCD L39455) [accessed 2026 Oct 12]

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- 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.
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- 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	
09/17/26	
Date	**Summary of Changes**
01/01/27	• Original effective date
10/19/26	• Policy edit, formatting correction to clarify intent of FJI/MBB.
10/15/26	• Policy edit, non-intent changing updates throughout the policy.
09/17/26	• New policy