Molina Clinical Policy
Injections and Nerve Blocks for Neck and Back Pain
Policy No. 468

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OVERVIEW

Chronic spinal pain, including pain originating from the cervical, thoracic, or lumbar spine, is a common condition that can significantly impact function, mobility, and quality of life. Common sources of pain include the sacroiliac joints, facet joints, or nerve roots (i.e., radiculopathy), each of which may be evaluated or managed using diagnostic and therapeutic injections adjunct to a comprehensive pain management program. Therapeutic injections are typically intended to provide temporary pain relief, reduce inflammation, and facilitate progress in rehabilitation efforts rather than long-term standalone treatment.

Sacroiliac joint (SIJ) pain refers to discomfort originating from the joint connecting the sacrum and ilium. The SIJ is the largest axial joint in the human body and functions primarily as a stabilizer rather than a moving joint, reinforced by multiple ligaments and muscles. Pain can arise from within the highly innervated joint itself or from adjacent supporting structures. The SIJ has been identified as a potential source of chronic low back pain, and may result from injury, degeneration, inflammation, or surgery (Sun et al. 2018; Wieczorek et al. 2021).

Facet joint pain is a type of spinal pain that originates from small synovial joints located between and behind adjacent vertebrae. The facet joints help to stabilize the spine and facilitate controlled motion. Over time, degenerative changes, injury, or inflammation can lead to pain that is typically localized to the affected region (i.e., cervical, thoracic, or lumbar) and may radiate in a non-dermatomal pattern. Diagnosis is often clinical, supported by imaging and confirmed through diagnostic injections, since physical exam and radiologic findings alone may not reliably identify the facet joints as the source of pain ([6-7]Hayes 2022).

Epidural steroid injections (ESI) can be used to manage radicular back and neck pain, typically after conservative, noninvasive treatments such as physical therapy and oral medications have failed to provide adequate relief. ESIs may be performed for both diagnostic and therapeutic purposes. Diagnostic injections are performed to verify the source of pain within a particular region of the spinal column using an anesthetic. Pain relief for several weeks following the diagnostic injection is indicative of inflammation within the area. Therapeutic injections are given to prolong pain relief and to reduce the inflammatory process over extended periods of time using a corticosteroid and anesthetic. The injection is administered into the epidural space or adjacent areas surrounding the spinal cord through an interlaminar, caudal, or transforaminal approach, and the procedure is commonly performed under fluoroscopic guidance to ensure accurate needle placement. The purpose of an ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs and avoiding surgery, but this treatment alone offers no significant long-term functional benefit ([4]Hayes 2022; Kothari & Chuang 2025; Chou 2026; [1]Hayes 2024).

Selective nerve root blocks (SNRBs) are typically performed for diagnosis of radicular pain at a specific level, and involves the injection of a local anesthetic, sometimes with contrast, near a specific spinal nerve root. The technique is similar to a transforaminal epidural injection; however, in an SNRB, the needle is positioned just outside the intervertebral foramen targeting the nerve root sheath, without entering the epidural space. When isolated nerve root irritation or compression is suspected, a SNRB can help identify the symptomatic level. A positive diagnostic response (i.e., temporary relief of radicular symptoms) supports the suspected nerve root as the pain generator. SNRBs can be used as a diagnostic adjunct prior to targeted interventions or spinal surgery ([4]Hayes 2022).

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Sacroiliac joint (SIJ) injections are a type of intra-articular injection that can be performed for both diagnostic and therapeutic purposes in treating low back pain. Diagnostic injections are used to confirm the SIJ as the source of pain by evaluating the patient's response to a local anesthetic. The current gold standard for SIJ diagnosis is the use of image-guided injections, typically fluoroscopy with contrast, to confirm intra-articular placement, followed by assessment of pain relief. For therapeutic purposes, corticosteroids may be injected into the joint to reduce inflammation and alleviate pain (Thawrani et al. 2019).

Facet joint injections and **medial branch blocks (MBBs)** are injection procedures used for diagnosing and managing chronic spinal pain suspected to originate from the facet joints in the cervical, thoracic, or lumbar spine. In a facet joint injection, the injection is placed directly into the facet joint capsule. In an MBB, the injection targets the medial branch nerves of the dorsal rami, which innervate the facet joints, without entering the joint itself ([7]Hayes 2022).

Cluneal Nerve Blocks are used as a proposed treatment for individuals with cluneal nerve entrapment syndromes causing pain in the low back and buttocks. The superior and the middle cluneal nerves are cutaneous nerves that are sensory and dominate sensation in the lumbar area and the buttocks. Entrapment of these nerves around the iliac crest can elicit low back pain. The superior cluneal nerve (SCN) provides sensory innervation to the areas of the posterior iliac crest and upper buttocks. It originates from the upper 3 lumbar spinal nerves (L1–L3), passes through the thoracolumbar fascia, and can be entrapped at the osteofibrous orifice where it penetrates the thoracolumbar fascia. The anatomic and functional bases for the development of SCN entrapment neuropathy are a rigid fascial edge and stretching of the gluteus maximus muscle and skin over a large area during flexion of the hip joint. If the nerve is chronically subjected to stretching, the resulting tissue irritation, edema, inflammatory cell infiltration, and scarring can lead to entrapment. Low-back pain caused by SCN entrapment is induced and exacerbated by movements such as rising, sitting, and rolling over, and by prolonged sitting, standing, or walking. Although the etiology of SCN entrapment neuropathy remains unclear, the symptoms are low-back pain (buttock pain) and paresthesia in the area of SCN innervations. Diagnosis of SCN entrapment neuropathy requires a positive result after a SCN block. Cluneal nerve blocks are performed under fluoroscopy where the physician injects one or more anesthetic agents and/or steroids near an affected cluneal nerve or branch to control pain and inflammation or to aid in diagnosis and treatment. The block is intended to interrupt the conduction of pain impulses and minimize the neuropathic pain and paresthesia associated with the SCN entrapment ([3]Hayes 2024; [2]Hayes 2025).

RELATED POLICIES

MCP-469: Radiofrequency Nerve Ablation for Neck and Back Pain

COVERAGE POLICY

Cluneal Nerve Block Injections

Cluneal nerve injections or blocks for the treatment of chronic low back pain are considered **experimental, investigational, and unproven** due to insufficient evidence in peer-reviewed medical literature to establish long-term safety, efficacy, and effect on net health outcomes

Diagnostic Selective Nerve Root Blocks (SNRBs)

Diagnostic selective nerve root block (SNRBs) may be **considered medically necessary** in the evaluation and diagnostic work-up of radicular pain when ALL the following criteria are met:

1. Member is ≥ 18 years old

2. At least ONE of the following criteria is met:
   a. Physical signs and symptoms differ from that found on imaging studies
   b. Clinical evidence of multi-level nerve root pathology, and the treatment plan requires isolating the pain source(s)
   c. Member has had previous spinal surgery
   d. Surgical planning

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Limitations and Exclusions

1. No more than one (1) SNRB at a single level is considered medically necessary, unless the first SNRB was non-diagnostic

2. SNRB performed at separate levels when multi-level nerve root pathology is suspected should not be performed within two (2) weeks of a prior injection
   Note: Injections should be administered with imaging guidance via fluoroscopic or computed tomography (CT). Ultrasound guidance is considered experimental, investigational, and unproven.

3. No more than six (6) SNRBs should be performed in a twelve (12) month period, regardless of the number of levels involved

Diagnostic Facet Joint Injections and Medial Branch Blocks (MBBs)

Diagnostic facet joint injections or medial branch blocks (MBBs) may be **considered medically necessary** for chronic cervical or lumbar pain, to determine the appropriateness for radiofrequency neurotomy, when ALL the following criteria are met:

1. Member is ≥ 18 years old

2. Presence of chronic severe pain, defined as persisting beyond three (3) months and affecting activities of daily living and functional ability (≥ 6 on Numeric Rating Scale [NRS] for Pain)

3. Physical evaluation and imaging studies suggest non-radicular, facet-associated pain with no other obvious cause of the cervical or lumbar pain (e.g., central spinal stenosis with neurogenic claudication/myelopathy; foraminal stenosis or disc herniation with concordant radicular pain/radiculopathy; infection; tumor; fracture; pseudoarthrosis; pain related to spinal instrumentation)

4. Inadequate response to a minimum of three (3) months of conservative therapy that includes ALL the following:
   a. Physical therapy for a minimum of eight (8) sessions, unless a documented contraindication or intolerance to physical therapy is provided
   b. Activity or exercise modification
   c. Pharmacologic therapy (e.g., nonsteroidal anti-inflammatory drugs [NSAIDS], muscle relaxants, corticosteroids, antidepressants, anticonvulsants, opioids)

5. Radiofrequency neurotomy is being considered

6. The diagnostic facet joint injections or MBBs will not be performed at more than four (4) joints (e.g., two [2] bilateral levels or four [4] unilateral levels) per session for each covered spinal region
   Note: Injections should be administered with imaging guidance via fluoroscopic or computed tomography (CT). Ultrasound guidance is considered experimental, investigational, and unproven.

7. Absence of previous history of spinal fusion in the area to be treated

Continuation of Therapy

A second diagnostic facet joint injection or MBB session to determine the appropriateness for a radiofrequency neurotomy are **considered medically necessary** when ALL the following criteria are met:

1. Performed to confirm the validity of the clinical response to the initial facet joint injection or block

2. Member had positive response to first injection, defined as ≥ 70% relief of the primary (index) pain and increase in functional ability with the onset and duration of relief being consistent with the local anesthetic employed. In the case of a longer duration anesthetic, a measured decrease in pain medication must also be documented.

3. Performed in the same location(s) as the initial diagnostic facet joint injection or MBB

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4. Performed at least one (1) week after initial diagnostic facet joint injection or MBB

5. Diagnostic facet joint injections or MBBs will not be performed at more than four (4) joints (e.g., two [2] bilateral levels or four [4] unilateral levels) per session for each covered spinal region

6. A maximum of six (6) facet joint procedural sessions per region (cervical or lumbar) may be performed in a twelve (12) month period

Limitations and Exclusions

Therapeutic facet joint injections or MBBs (e.g., more than two [2] facet injections or MBBs at the same level) are considered **experimental, investigational, and unproven** due to insufficient evidence in the peer-reviewed medical literature to establish long-term safety, efficacy, and effect on net health outcomes

Facet joint injections in the thoracic region are considered **experimental, investigational, and unproven** due to insufficient evidence in the peer-reviewed medical literature to establish long-term safety, efficacy, and effect on net health outcomes

Epidural Steroid Injections (ESIs)

Epidural steroid injections (ESI) may be **considered medically necessary** for radicular neck or back pain, as part of a comprehensive pain management program, when ALL the following criteria are met:

1. Member is ≥ 18 years old

2. Absence of spinal stenosis resulting in intraspinal obstruction, previous fusion at the indicated spinal level, or other spinal pathology (e.g., spinal tumors, cauda equina syndrome, spinal cord compression)

3. For **Initial Diagnostic Injections** (up to two [2] injections), Member must meet ALL the following criteria:
   a. History, physical examination, and radiologic imaging support ONE of the following:
      i. Cervical, thoracic, or lumbar radicular pain, radiculopathy, or neurogenic claudication (lumbar)
      ii. Post-surgical neck or back pain (e.g., post laminectomy syndrome) due to prior surgery (e.g., discectomy, laminectomy, or spinal fusion) and at least six (6) months have elapsed since surgery
      iii. Acute pain associated with herpes zoster
   b. Pain that affects activity of daily living functional ability (≥ 4 on the NRS for Pain)
   c. Inadequate response to a minimum of three (3) months of conservative therapy that includes ALL the following:
      i. Physical therapy for a minimum of eight (8) sessions, unless a documented contraindication or intolerance to physical therapy is provided
      ii. Activity or exercise modification
      iii. Pharmacologic therapy (e.g., NSAIDS, muscle relaxants, corticosteroids, antidepressants, anticonvulsants, or opioids)
      iv. **Exception:** Herpes zoster associated pain has failed conservative measures and a waiting period is not appropriate
   d. Maximum of two (2) injections per region with injections at least two (2) weeks apart
      i. Transforaminal injection(s): no more than two (2) transforaminal injections may be performed per session (i.e., single level bilaterally or two levels unilaterally)
      ii. Caudal or interlaminar injection: no more than one (1) caudal or interlaminar injection per session and not in conjunction with a transforaminal injection (it is not reasonable and necessary to perform caudal or interlaminar injections bilaterally)
      Note: Injections should be administered with imaging guidance via fluoroscopic or computed tomography (CT). Ultrasound guidance is considered experimental, investigational, and unproven.

4. For **Repeat Therapeutic Injections,** Member must meet ALL the following criteria:
   a. Diagnostic or last therapeutic injection for the current episode of pain must have provided significant functional pain relief as evidence by ONE of the following:
      i. ≥ 50% relief of the primary (index) pain

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ii. Decrease in pain medication usage
iii. Increase in physical function

b. Diagnostic or last therapeutic injection for the current episode of pain must have provided significant functional pain relief for at least six (6) weeks
c. Maximum of four (4) injections total per region (cervical/thoracic or lumbar) per rolling twelve (12) month period, inclusive of any diagnostic injections. *Note: Cervical and thoracic regions are considered one region for purposes of this limitation.* Additionally, injections should be administered with imaging guidance via fluoroscopic or computed tomography (CT). Ultrasound guidance is considered experimental, investigational, and unproven.
    i. Transforaminal injection(s): no more than two (2) transforaminal injections may be performed per session (i.e., single (1) level bilaterally or two (2) levels unilaterally)
    ii. Caudal or interlaminar injection: no more than one (1) caudal or interlaminar injection per session and not in conjunction with a transforaminal injection (it is not reasonable and necessary to perform caudal or interlaminar injections bilaterally)

Sacroiliac Joint (SIJ) Injections

Sacroiliac joint (SIJ) injections (local anesthetics with or without corticosteroids) for treatment of chronic severe low back pain may be **considered medically necessary** as part of a comprehensive pain management program, when ALL the following criteria are met:

1. Member is ≥ 18 years old

2. Physical examination documentation reveals ALL the following:
    a. Non-radicular low back pain (≥ 6 on NRS for pain) below the level of L5 vertebra for a minimum of three (3) months causing functional disability
    b. Exam findings consistent with SIJ pain (i.e., localized tenderness with palpation over the sacral sulcus, pain localized over posterior SIJ)
    c. Positive response (pain) to at least 3 of the following provocative tests:
        i. Patrick's or FABER
        ii. Gaenslen
        iii. Thigh thrust
        iv. Sacral thrust
        v. Distraction
        vi. Compression

3. Inadequate response to a minimum of three (3) months of conservative therapy that includes ALL the following:
    a. Physical therapy for a minimum of eight (8) sessions, unless a documented contraindication or intolerance to physical therapy is provided
    b. Activity or exercise modification
    c. Pharmacologic therapy (e.g., NSAIDS, muscle relaxants, corticosteroids, antidepressants, anticonvulsants, opioids)

Limitations and Exclusions

1. For **Diagnostic Injections:** Two (2) total injections for diagnosis may be given no less than one (1) week apart, preferably two (2) weeks apart
   Note: Injections should be administered with imaging guidance via fluoroscopic or computed tomography (CT). Ultrasound guidance is considered experimental, investigational, and unproven.

2. For **Therapeutic Injections**:
    a. A member must be experiencing a return of pain or deterioration in function to receive a therapeutic injection
    b. Diagnostic or last therapeutic injection for the current episode of pain must have provided significant functional pain relief, as evidence by ONE of the following for a minimum of two (2) months before subsequent injections within the same region are authorized:
        i. ≥ 50% relief of the primary (index) pain
        ii. Decrease in pain medication usage

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iii. Increase in physical function

c. Two (2) months or longer between each injection in the same joint, not to exceed a total of four (4) injections in one region per year
d. Injections at different joints can be given two (2) weeks apart, but no sooner than one (1) week following an injection in a different region
e. A maximum of four (4) injections total per rolling calendar year may be given for local anesthetic and corticosteroid injections
f. Only one type of a block or injection (e.g., sacroiliac, epidural) should be performed in each session so that the effectiveness of its treatment can be assessed prior to attempting another type of spinal block or injection

Note: Injections should be administered with imaging guidance via fluoroscopic or computed tomography (CT). Ultrasound guidance is considered experimental, investigational, and unproven.

3. **Lateral nerve blocks** for diagnosing or treating acute, subacute, or chronic SIJ pain procedures are considered **experimental, investigational, and unproven** due to insufficient evidence in the peer-reviewed medical literature to establish long-term safety, efficacy, and effect on net health outcomes

DOCUMENTATION REQUIREMENTS. Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

SUMMARY OF MEDICAL EVIDENCE

Cluneal Nerve Block Injections

Randomized Controlled Trials

Nielsen et al. (2019) published findings from a randomized controlled trial (RCT) that describes a novel ultrasound guided superior cluneal nerve (SCN) block technique for application in the management of postoperative pain after hip surgery as well as other clinical uses such as chronic low back pain. “The study was carried out as two separate investigations. First, dissection of 12 cadaver sides was conducted to test a novel SCN block technique. Second, this technique was applied in a randomized trial of 20 healthy volunteers. Initially, the lateral femoral cutaneous, the subcostal and the iliohypogastric nerves were blocked bilaterally. A transversalis fascia plane (TFP) block technique was used to block the iliohypogastric nerve. Subsequently, randomized, blinded SCN blocks were conducted with active block on one side and placebo block contralaterally.” The results showed that “successful anesthesia after the SCN block was achieved in 18 of 20 active sides (90%). The area of anesthesia after all successful SCN blocks was adjacent and posterior to the area anesthetized by the combined TFP and subcostal nerve blocks. The addition of the SCN block significantly increased the anesthetic coverage of the several types of hip surgery incisions.” The authors concluded that “the novel ultrasound-guided nerve block technique reliably anesthetizes the SCNs. It anesthetizes the skin posterior to the area innervated by the iliohypogastric and subcostal nerves. It improves the anesthetic coverage of incisions used for hip surgery. Among potential indications, this new nerve block may improve postoperative analgesia after hip surgery and may be useful as a diagnostic block for various chronic pain conditions.” The authors indicated that clinical trials are mandated. Limitations of this study include small sample size, healthy subjects without back pain were utilized and there was no randomization to any other low back pain treatment for comparison other than placebo.

Non-Randomized Studies, Retrospective Reviews, and Other Evidence

Yıldırım Uslu (2024) conducted a single-center retrospective study to compare ultrasound-guided perineural dextrose injection with steroids for the treatment of SCN entrapment neuropathy. The study included 33 adults with mechanical low back pain radiating to the iliac crest and hip for greater than 3 months and who experienced $\geq$ 50% pain relief following an ultrasound-guided diagnostic anesthetic. For the study, 17 patients received 5% dextrose and 16 received a steroid injection. Clinical outcomes were assessed using the visual analogue scale (VAS) for pain and the Roland-Morris Disability Questionnaire (RMDQ) for functional disability, assessed pre-injection and post-injection at 1 week. For the dextrose group, baseline mean VAS scores were 5.81 ± 0.98 and RMDQ scores were 13.31 ± 1.92. At 1 week post-injection, VAS scores were 1.63 ± 1.08 and RMDQ scores were 4.31 ± 1.62. For the steroid group, baseline mean

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VAS scores were 6.13 ± 0.96 and RMDQ scores were 13.38 ± 1.15. At 1 week, VAS scores were 2.50 0.52 and RMDQ scores were 5.81 ± 1.33. Post-injection outcomes favored the dextrose group, showing statistically lower VAS scores (p = 0.016) and RMDQ scores (p = 0.009). Limitations include lack of randomization or bling, small sample size, retrospective and single-center design, and a very short follow-up period. The authors concluded that ultrasound-guided perineural dextrose injections are a safe and effective alternative to steroid injections for the treatment of SCS neuropathy. Higher-quality, larger scale studies are needed.

Gautam et al. (2022) completed a prospective observational study to evaluate the therapeutic role of a single lidocaine injection into the SCN for the treatment of low back pain associated with SCN entrapment. The study included 25 patients aged 18-60 years with unilateral low back pain over the iliac crest and buttocks regions for more than 6 months that did not respond to conservative treatment. Patients also had to experience pain relief of > 50% on a numeric rating scale for at least 2 hours after a fluoroscopy guided lidocaine injection. Patients were excluded from the study if they had received any form of surgery or developed infectious diseases or malignancy of the spine, had uncontrolled medical diseases, or had uncontrolled psychiatric ailments. Patients received follow-up over a period of 6 months. Of the 25 patients included in the study, 23 completed all 6 months of follow-up. Approximately 80% of study participants continued to have significant pain relief after 6 months of follow-up following a single lidocaine injection into the SCN.

Diagnostic Selective Nerve Root Block (SNRB)

Systematic Reviews and Meta-Analyses

Fang et al. (2022) completed a systematic review and meta-analysis to compare the clinical efficacy of SNRBs using local anesthetic (LA) alone and a combination of steroids and LA (steroids+LA) for the treatment of degenerative disc disease. Inclusion criteria included studies with patient aged ≥ 18 years diagnosed with degenerative disc disease based on radiological evaluation (CT or MRI scans) and clinical manifestations of neck or waist pain along with nerve root pain. Exclusion criteria included a history of spinal surgery, nonspecific pains that were not definitively diagnosed as lumbar intervertebral or cervical disc herniation based on radiological exam, severe spinal canal stenosis, severe intervertebral disc degeneration, intravertebral disc disorders or herniations, and significant spinal instability. Outcomes measured were pain and functional measurement. Pain was reported using the Numeric Rating Scale (NRS) and VAS scales and both were considered equivalent and interchangeable for analysis. Follow-up ranged from 1 week to 2 years depending on the RCT. The follow-up selected for analysis were 3, 6, 12, 18, and 24 months due to the clinical significance of data at each of these time periods. A total of 22 RCTs reported follow-up at 3-months with all reporting NRS and Oswestry Disability Index (ODI) data. The mean deviation of NRS was 0.19 and the mean deviation of ODI was 0.98 with both showing steroids+LA as superior to LA alone. Nineteen RCTs reported NRS data and 13 reported ODI data at 6-months. The mean deviation of NRS was 0.11 with no significant difference between either group. However, the mean deviation of ODI was 1.13 with steroids+LA being superior. Nineteen RCTs reported NRS data and 15 reported ODI data at 12-months. The mean deviation of NRS was 0.11 with no significant difference between either group. The mean deviation of ODI was 0.94 with steroids+LA being superior. The same 9 RCTs reported NRS and ODI data at 18-months and 24-months. The mean deviation of NRS at 18-months was 0.10 and 24-months was 0.18 with no significant difference between either group. The mean deviation of ODI at 18-months was 0.73 and 24-months was 0.70 with no significant difference between either group.

Beynon et al. (2019) performed a systematic review to examine the diagnostic accuracy of SNRBs for identifying patients with lumbar radiculopathy (LR) who may benefit from lumbar decompression surgery. The review included six primary diagnostic test accuracy studies, with four being cohort studies and two being case-control studies, for a total of 341 (n = 341) patients, all who had low back pain and radicular symptoms undergoing SNRB under imaging guidance. All studies were judged to be at high risk of bias, especially due to verification and patient selection bias. Verification bias occurred because surgical outcomes, which are often used as a reference standard, were predominately obtained in patients who tested positive of the SNRB, leaving few surgical data on SNRB-negative patients. The patient selection bias in the case-control studies stemmed from recruiting participants with concordant imaging and clinical findings, which is not representative of the diagnostic uncertainty seen in clinical practice. Diagnostic accuracy results showed wide variability, with sensitivities ranging from 57% to 100% and specificities from 10% to 86%. Among the cohort studies, pooled sensitivity was 93.5% (95% CI: 84.0-97.6%) when intraoperative findings were used as the reference standard, and 90.9% (95% CI: 83.1-95.3%) when surgical outcomes were used. Pooled specificity was low, with 50.0% (16.8-83.2%) for intraoperative reference and 22.0% (7.4-49.9%) for surgical outcomes. These findings indicate that while SNRB is sensitive in identifying patients with nerve root pathology, it has low specificity and may incorrectly identify patient without the condition. Adverse events associated with SNRB were minimal. The largest case series found an overall per patient visit complication rate of 5.5% and a per injection

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complication rate of 6%, with no major or permanent complications reported. The authors concluded that there is limited and low-quality evidence supporting the diagnostic accuracy of SNRB, particularly due to the test's low specificity. SNRB is a safe diagnostic procedure and has uncertain value in clinical decision-making. More high-quality research is needed to determine whether SNRB contributes meaningfully to patient outcomes or surgical planning.

Diagnostic Facet Joint Injections and Medial Branch Blocks (MBBs)

Randomized Controlled Trials

Lee et al. (2022) conducted a randomized controlled trial of one hundred patients with severe lumbar central spinal stenosis (LCSS). Participants were assigned to either the facet injection group where they received an injection of steroids and botulinum toxin type A or the transforaminal epidural steroid injection (TFESI) group. Patients were included if they were between 20 and 79 years, ≥ 3 months history of lower leg pain due to LCSS, and pain intensity of >5 on NRS or extreme LCSS on magnetic resonance imaging. Patients were excluded if they had a herniated lumbar disc, myelopathy, or infection on the spine; more than one segment of severe or extreme LCSS; history of spinal surgery; coagulation disorder; osteoporotic compression fracture; multiple-level spinal stenosis; vascular stenosis in lower extremity; or severe deterioration of general condition. The main outcomes in the study were changes in leg pain measured by the NRS and functional disability measured by the modified ODI. In the facet injection group the pretreatment NRS was 5.7, 3.6 at 4 weeks, 5.1 at 8 weeks and 5.3 at 12 weeks after injection. In the TFESI group the pretreatment NRS was 6.6, 5.1 at 4 weeks, 5.1 at 8 weeks, and 5.3 at 12 weeks after injection. Scores for both groups were significantly decreased compared to pretreatment scores ($p < 0.001$). Modified ODI scores in the facet injection group decreased after treatment, the pretreatment modified ODI was 62.0, 45.7 at 4 weeks, 44.3 at 8 weeks, and 45.4 at 12 weeks after injections. The modified ODI scores in the TFESI were 61.6 pretreatment, 54.2 at 4 weeks, 53.2 at 8 weeks, and 54.3 at 12 weeks after injection. In both groups the ODI score was significantly decreased ($p < 0.001$). Limitations of the study included lack of long-term follow-up, lack of placebo comparison, and a small population number. The study concluded that leg pain and functional disability was significantly reduced after facet injection and overall, the facet injection had a better therapeutic effect compared to the TFESI.

Systematic Reviews and Meta-Analyses

Manchikanti et al. (2025) performed a systematic review and meta-analysis of RCTs evaluating the therapeutic effectiveness of intra-articular facet joint injections for chronic axial spinal pain involving the cervical, thoracic, or lumbar spine. A total of 14 RCTs were included in the review, with 10 RCTs being for the lumbar spine (n = 531), 3 RCTs being for the cervical spine (n = 281), and 1 RCT being for the thoracic spine (n = 40), for a total of 852 participants. The primary outcome was pain relief and functional improvement, defined as either a ≥ 2-point reduction on the VAS or NRS, or a ≥ 50% reduction in pain accompanied by functional improvement, sustained for at least 3 months. Due to significant heterogeneity across all RCTs, a meta-analysis comparing treatment vs. control could not be performed, and only 4 RCTs were eligible for pooled analysis. Single-arm meta-analysis of lumbar injections showed a pooled mean pain reduction of 2.51 points (95% CI -3.18 to -1.84) at 3 months and 2.70 points (95% CI -3.39 to -2.00) at 6 months with dexamethasone. In lumbar studies, some trials reported statistically significant improvements in pain and function, but several were negative or clinically indeterminate. For example, McCormic et al. (2023) found that only 25% of patients receiving intra-articular steroid injections met responder criteria at 3 months and that steroid injections were inferior to radiofrequency neurotomy. For cervical trials, Allison et al. (2024) found only 21% of participants in the steroid group achieved ≥ 50% relief at 3 months. Qualitative synthesis classified the overall body of evidence as Level IV (limited evidence), and GRADE assessment concluded low certainty with a low strength of recommendation. The authors noted a continued scarcity of high-quality literature for therapeutic facet joint injections. The authors concluded that based on qualitative analysis and GRADE assessment, therapeutic intra-articular facet joint injections for chronic axial pain are supported by Level IV evidence, with limited quality, low certainty, and a low strength of recommendation.

Suputtitada et al. (2023) performed a systematic review and meta-analysis to compare patient reported outcomes after intra-articular facet joint injections with normal saline versus active substances (e.g., corticosteroid and/or local anesthetic) for subacute and chronic low back pain. The included studies were all RCTs, for a total of 247 participants, and all trials used fluoroscopic guidance for injections. The primary outcome was pain, measured by VAS on a 0-100 mm scale. Secondary outcomes included disability, measured by ODI or other disability scores, quality of life, measured by the Sickness Impact Profile, numbness, and adverse events. Meta-analysis demonstrated no significant differences between normal saline and active substances for pain reduction at 1 hour (MD 2.43, 95% CI -11.61 to 16.50), at 1-1.5 months (MD -0.63, 95% CI −7.97 to 6.72), or at 3-6 months (MD 1.90, 95% CI -16.03 19.83). Sensitivity analysis using an alternative method for standard deviation showed similar results. However, study limitations include heterogeneity in population age, types of active substances used, locations of back pain, follow-up times, and outcome

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measurements. The authors concluded that the short and long-term clinical outcomes of intra-articular facet joint injections with normal saline are comparable to active substances in patients with subacute and chronic low back pain. However, normal saline may not necessarily function simply as a placebo, as other potential mechanisms such as dilution of inflammatory mediators, water-jet-related disruption of calcification, and desensitization may impact therapeutic effects. More robust research is required.

Baroncini et al. (2021) performed a systematic review comparing results of facet joint injections and MBBs obtained with different compounds in the management of low back pain originating from facet joints. A literature search identified data from 587 patients; mean follow-up was 12.4 ± 10.5 months, mean age was 51.3 ± 9.6 years old, and 57% patients were women. The authors reported that steroids reduced the numeric rating scale by 28% ($p < 0.0001$) and ODI improvement by 13% ($p < 0.0001$). Local anesthetics promoted an improvement of the ODI by 9.8% ($p < 0.0001$). Sarapin resulted in a reduction of NRS by 44% ($p = 0.04$) and an improvement the ODI by 15% ($p = 0.004$); combined with steroids, sarapin promoted a reduction of NRS by 47% ($p = 0.04$) and an improvement of the ODI by 12% ($p = 0.001$). Authors concluded that patients that received facet joint injections and MBB had significant improvement in NRS and ODI scores one year after treatment.

Epidural Steroid Injections (ESI)

In 2014, the U.S. Food and Drug Administration (FDA) issued a safety warning about the use of injectable corticosteroids into the epidural space to treat neck and back pain, cautioning that these injections may result in rare, but serious adverse events, such as loss of vision, stroke, paralysis, and death. Despite their widespread clinical use, the FDA has not approved corticosteroids for epidural administration, and their safety and efficacy for this purpose has not been established (FDA 2016).

Randomized Controlled Trials

Manchikanti et al. (2014) conducted an RCT involving 110 patients suggests that ESI for the treatment of thoracic radicular pain results in clinically significant reductions in pain from baseline and has similar outcomes as treatment with anesthetic injection alone. Group I was treated with injections with local anesthetic while Group II received injections with local anesthetic with steroids. Repeat thoracic ESIs were provided based on positive response to prior epidural injections only when increased levels of pain were reported by the subjects. Outcomes were assessed at 3, 6, 12, 18, and 24 months using the NRS, ODI, employment status, and opioid intake. A successful outcome was considered as greater than 3 weeks of significant improvement (greater than 50% decrease in NRS score and ODI score measured at baseline) following the first two injections. Significant improvement was seen in 71% in Group I and 80% in Group II at the end of two years with all participants, or 80% and 86% respectively when only successful patients were included. A major limitation of this study is the lack of placebo group. Disc related pathology, spinal stenosis, and post spinal surgery syndrome are much less common in the thoracic region than in the cervical or lumbar regions, thus the body of evidence studying thoracic ESI is much smaller than that for cervical or lumbar ESI (ASIPP 2021).

Systematic Reviews and Meta-Analyses

Zhang et al. (2024) conducted a systematic review and meta-analysis to evaluate the effectiveness of epidural steroid injections for sciatica caused by lumbar disc herniation. The analysis included 11 randomized controlled trials (RCTs) with a total of 978 participants: 485 in the test group and 493 in the control group. Eligible studies had to involve patients with sciatica confirmed to be caused by lumbar disc herniation, use one of three steroid injection approaches (caudolateral, interlaminar, or intervertebral foraminal), and have a control group receiving either a local anesthetic or placebo. Excluded studies involved sciatica from other causes, patients with a history of lumbar disc surgery, postoperative epidural steroid injections, or neuralgia from cervical or thoracic disc herniation. The primary outcome was pain relief, measured by the NRS and VAS. Secondary outcomes included functional recovery (assessed by Roland Morris Disability Questionnaire (RMDQ) and ODI scores), opioid use, and adverse events. At three months post-intervention, there was a significant difference in pain relief between the control and treatment groups ($p = 0.0003$). At six months, eight articles showed a significant difference in NRS scores ($p = 0.02$). Functional improvement, measured by RMDQ, did not show significant differences one-month post-intervention ($p = 0.38$). Nine studies reporting ODI scores also showed no significant differences between groups at one month ($p = 0.19$) or at 12 months ($p = 0.49$). Four studies reported a significant reduction in opioid use at three months post-intervention ($p = 0.005$). Adverse events were reported in eight studies, with incidence rates ranging from 0.3% to 3.5%. Overall, the meta-analysis concluded that epidural steroid injections provide short-term pain relief and reduce opioid use in patients with sciatica due to lumbar disc herniation, but do not significantly improve functional outcomes.

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Conger et al. (2020) completed a systematic review and meta-analysis of 8 studies with the objective of comparing fluoroscopy guided cervical transforaminal ESI to sham, placebo, or active treatments. The primary outcome measured for the meta-analysis was a pain reduction of ≥ 50% compared to baseline. Inclusion criteria included patients ≥ 18 years of age with cervical radicular pain due to disc herniation or degenerative spondylosis and outcomes reported at least 4 weeks after intervention. Studies that had a comparison group not meeting criteria (sham, placebo, or active treatment) were still included in the analysis as a single-group study and only the ESI data was extracted for analysis. Exclusion criteria included case reports, expert opinions, and unpublished data. Results were divided up into particulate and non-particulate based on the type of steroid the patient received for ESI. Results were reported based on "success rate" or the percentage of patients that had a pain reduction ≥ 50%. For particulate steroids, analysis showed success rates of 41% at 1-month and 48% at 3-months. The combined success rate (1-month and 3-months) was 43%. For non-particulate steroids, analysis showed success rates of 56% at 1-month and 68% at 3-months. The combined success rate was 64%. No serious adverse events were reported from the included studies. There were few minor side effects reported, including "cases of syncope and transient vertigo (n=3), transient dizziness, headache, or facial flushing (n=14), transient dizziness or nystagmus (n=3), increased pain in the arm or neck (n=3), and transient Horner syndrome (n=2)."

Yang et al. (2020) completed a meta-analysis of 6 RCTs with the goal of comparing the clinical effectiveness of ESI to conservation treatments for patients with lumbosacral radicular pain. Conservative treatments consisted of physical therapy, lifestyle modifications, exercise, and education. The meta-analysis included a total of 490 patients with 249 patients receiving ESI and 241 receiving conservative treatments. Inclusion criteria for RCTs included patient populations that were ≥ 18 years of age diagnosed with lumbar disc herniation or spinal stenosis that was confirmed using clinical or radiological evaluations. Exclusion criteria included review articles, abstracts, letters, case reports, absence of outcomes of interest (ODI, NRS, VAS, and successful events). Post-injection follow-up pain scores (NRS and VAS) were reported in 5 of the RCTs. Follow-up periods were standardized to short-term (< 1 month), intermediate-term (1-3 months), and long-term (6 months-1 year). Short-term and intermediate-term follow-up periods were reported for pain scores by 3 RCTs with the pooled analysis showing ESI providing a significant reduction in pain compared to conservative treatments. Long-term follow-up periods were reported for pain scores by 2 RCTs (different from the short- and intermediate-term follow-up periods) with the pooled analysis showing that ESI was not more effective than conservative treatments. Functional improvement was determined using ODI and was reported in 4 RCTs. Short-term follow-up (1-3 months) was reported by 3 RCTs with pooled analysis showing equal effect between ESI and conservative treatments. Intermediate-term follow-up (3-6 months) showed no significant differences between ESI and conservative treatment. Successful events were dependent upon individual studies and included the degree of overall improvement, reduction of ≥ 2 in leg pain scores, VAS reduction of > 20%, and patient satisfaction scores. Results for successful events were standardized based on criteria from each individual study. Pooled analysis showed that ESI had a significantly higher number of successful events when compared to conservative treatments.

Sacroiliac Joint (SIJ) Injections

Randomized Controlled Trials

Jee et al. (2014), in a RCT of 120 patients (n = 120) with noninflammatory SI arthritis, ultrasound (US)-guided SIJ injections, compared to fluoroscopic-guided SIJ injections to evaluate the short-term efficacy and safety of US and fluoroscopic -guided SIJ injections. Patients were not blinded, but an investigator who was blinded assessed their pain, disability, and satisfaction. The fluoroscopic -guided SIJ approach was more accurate than the US-guided approach (98.2% versus 87.2%). The function and pain relief of both groups improved without significant differences. The US-guided strategy is just as effective as the fluoroscopic -guided strategy; however, the SIJ's lower diagnostic accuracy rate may limit its diagnostic utility.

Visser et al. (2013) conducted a randomized controlled trial compared the short-term efficacy of 3 treatments in 51 patients (n=51) with chronic SIJ-related leg pain: fluoroscopic-guided SIJ injection with lidocaine plus triamcinolone, PT, and manual therapy. SIJ-related pain was not confirmed by diagnostic injection. The findings indicate that treatment effectiveness rates (as measured by pain relief) between the SIJ injection (50%), manual therapy (72%) or PT groups (20%). Manual therapy was substantially more effective than PT. There were no reported side effects from the treatment. The limitations of this study include a small sample size and lack of power analysis, a single-blind design, a short duration of follow-up, a lack of diagnostic injections to confirm the diagnosis of SIJ pain, possible selection bias during patient recruitment, and a failure to rule out discogenic causes of low back pain as opposed to SIJ pathology.

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Systematic Reviews and Meta-Analyses

Janapala et al. (2023) conducted a systematic review and meta-analysis to assess the efficacy of therapeutic sacroiliac joint injections. The analysis included 11 RCTs and 3 observational studies, involving 641 patients. The primary outcomes evaluated were pain relief measured by the VAS or NRS and functional status measured by the ODI. Outcomes were considered clinically significant if there was a reduction of 3 points on the VAS or NRS, 50% decrease in pain coupled with improved functional status. Positive outcomes were observed in five RCTs and two observational studies. Pain scores decreased by 2.979 points ($p < 0.0001$) at three months across eight studies, and functional scores decreased by 18.057 points ($p < 0.0001$) across four studies. At six months, pain scores decreased by 3.069 points ($p < 0.0001$) based on three studies, and ODI scores decreased by 5.240 points ($p < 0.0001$) across three studies. However, the review is constrained by a lack of eligible studies, discrepancies among available studies, methodological variations, and inconsistent diagnostic criteria. Despite these limitations, the evidence suggests that therapeutic sacroiliac joint injections offer moderate support for managing low back pain originating from the sacroiliac joint.

Non-Randomized Studies, Retrospective Reviews, and Other Evidence

[3]Hayes (2024) performed a health technology assessment was conducted to evaluate the efficacy and safety of SIJ corticosteroid injections in the management of SIJ pain and low back pain among adult individuals. The quality of evidence pertaining to the effectiveness of such injections was deemed to be low. Among the six studies encompassed within the assessment, two reported a significant improvement in pain outcomes after corticosteroid injections when compared to baseline measurements. Comparative analysis with alternative therapies, such as platelet-rich plasma injections, manual therapy, physical therapy, and standard radiofrequency ablation, demonstrated a comparable efficacy profile. However, due to variances observed in patient selection criteria, treatment protocols, comparators utilized, assessment intervals, and the absence of prolonged follow-up evaluations, the effectiveness of SIJ corticosteroids remains uncertain. Consequently, the health technology assessment inferred weak evidential support for the utilization of SIJ corticosteroid injections in the management of SIJ-related discomfort and low back pain among the adult populace.

National and Specialty Organizations

The **American College of Physicians (ACP)** published an evidence-based clinical practice guideline on *Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain.* The ACP made the following recommendations (Qaseem et al. 2017):

- Nonpharmacologic treatment should include superficial heat (moderate-quality evidence), massage, acupuncture, or spinal manipulation (low-quality evidence). If pharmacologic treatment is desired, the provider and patient should select nonsteroidal anti-inflammatory drugs or skeletal muscle relaxants (moderate-quality evidence). (Grade: strong recommendation)
- For patients with chronic low back pain, clinicians and patients should initially select nonpharmacologic treatment. This may include exercise, multidisciplinary rehabilitation, acupuncture, mindfulness-based stress reduction (moderate-quality evidence), tai chi, yoga, motor control exercise, progressive relaxation, electromyography biofeedback, low-level laser therapy, operant therapy, cognitive behavioral therapy, or spinal manipulation (low-quality evidence). (Grade: strong recommendation)
- For patients who've had an inadequate response to nonpharmacologic therapy, providers should consider pharmacologic treatment with nonsteroidal anti-inflammatory drugs as a first-line therapy, or tramadol or duloxetine as second-line therapy. Opioids should only be considered in patients who have failed the previously mentioned treatments and only if the potential benefits outweigh the risks and after discussion of known risks and realistic benefits (moderate-quality evidence). (Grade: weak recommendation)

The **American College of Radiology (ACR)** (2021) published *Appropriateness Criteria: Low Back Pain* which provides evidence-based guidelines reviewed annually by a multidisciplinary expert panel. According to the Institute for Clinical Systems Improvement, subacute back pain lasts 4-12 weeks while chronic pain extends beyond 12 weeks. The ACR recommends imaging for patients who've had at least 6 weeks of medical management and physical therapy but with minimal or no improvement. Imaging is also recommended for patients that present with symptomology for a serious underlying condition (e.g., cauda equina syndrome, malignancy, fracture, infection). The ACR notes that bone mass decreases with age and that patients > 65 years of age may be considered at risk for osteoporotic fracture when presenting with low back pain (Hutchins et al. 2021).

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The **American Society of Anesthesiologists (ASA)** and **American Society of Regional Anesthesia and Pain Medicine (ASRA)** (2010) published *Practice Guidelines for Chronic Pain Management* and recommend the following:

- Physical or restorative therapy may be used as part of a multimodal strategy for patients with low back pain.
- ESIs with or without local anesthetics should be used for radicular pain or radiculopathy as part of a multimodal treatment regimen to provide pain relief in selected patients.
- Image guidance (e.g., fluoroscopy) should be used for both interlaminar and transforaminal epidural injections. Image guidance for transforaminal epidural injections represents current practice.
- Shared decision making regarding ESIs should include a specific discussion of potential complications, particularly regarding the transforaminal approach.
- Intraarticular facet joint injections and MBBs may be used for symptomatic relief of facet-mediated pain. Sacroiliac joint injections may be considered for symptomatic relief of sacroiliac joint pain.
- Conventional (80°C) or thermal (67°C) RFA of the medial branch nerves to the facet joint should be performed for low back pain when previous diagnostic or therapeutic injections of the joint or medial branch nerve have provided temporary relief.

The **ASRA** published *Consensus Practice Guidelines on Interventions for Lumbar Facet Joint Pain*. Uncontrolled facet blocks have a high false-positive rate, are costly, and have inherent risks. Prospective studies of facet joint injections typically require conservative treatment before study enrollment, and the ASRA recommends 3 months of conservative treatment before considering facet joint interventions. Regarding imaging, fluoroscopy is the gold standard for facet blocks, and Spine Intervention Society (SIS) guidelines list fluoroscopy as mandatory for lumbar MBBs. While the use of ultrasound is growing, it has significant limitations. Overall, the ASRA recommends CT or fluoroscopy for lumbar MBBs and intra-articular injections. For diagnostic blocks and injections, they are useful but not without inherent flaws. They assume there are no other factors that will alter pain and they rely on the patient's report of pain relief which is subject to bias and cannot be independently verified. The ASRA recommends a $\geq$ 50% reduction in pain be used as the threshold to designate a block as positive but also recognizes that using higher cut-off values may result in higher RFA success rates. The SIS recommends that the cut-off for a positive block be 80% rather than 50%, and that two positive blocks should be routinely required. Regarding therapeutic facet joint injections, the ASRA states that the use of corticosteroids is controversial and is based on the theory that an inflammatory component is responsible for symptoms. For MBB, the theoretical foundation is even weaker, based on the theory of entrapment neuropathy, which is most common at L5. Based on current medical evidence, the ASRA recommends against therapeutic MBBs and intra-articular injections (Cohen et al. 2020).

The **ASRA** and **American Academy of Pain Medicine (AAPM)** published *Consensus Practice Guidelines on Interventions for Cervical Facet Joint Pain*. The guidelines share similar recommendations as with the lumbar spine, such as a recommended $\geq$ 50% pain reduction for a positive block, use of conservative treatment before considering facet joint interventions, and use of imaging guidance for intra-articular injections and MBBs. Similarly to the lumbar spine, the ASRA recommends against therapeutic MBBs and intra-articular injections, especially given the lack of pathophysiological basis for prolonged relief and the known risks. The ASRA also emphasizes the increased risk of serious adverse outcomes with the cervical spine, such as permanent neurologic injury or death due to direct trauma from the needle (Hurley et al. 2022).

The **ASRA** and **AAPM** published *Consensus Practice Guidelines on Sacroiliac Joint Complex Pain*. The neuroanatomy of the SIJ remains incompletely characterized, and this anatomical complexity has led to debate regarding the diagnostic validity of intra-articular SIJ injections and blocks. Systematic reviews partially support their diagnostic validity, but more research is needed. Overall, based on Grade B evidence and a moderate level of certainty, intra-articular SIJ injections are diagnostically valid for SIJ-mediated pain. The goal of a diagnostic SIJ injection serves not only to confirm that lower back pain is SIJ-mediated, but to help predict responses to more definitive interventions, such as surgical joint fusion or RFA. For therapeutic SIJ injections, the evidence shows that both intra- and extra-articular steroid injections may provide at least 4 weeks of pain relief in well-selected patients. In those with suspected SIJ pathology, imaging guidance (fluoroscopy or CT) is strongly recommended. In patients where radiation exposure and/or contrast is contraindicated, ultrasound guidance should be considered (McCormick et al. 2025).

The **American Society of Interventional Pain Physicians (ASIPP)** evidence-based guidelines on *Epidural Interventions in the Management of Chronic Spinal Pain* states the following (Manchikanti et al. 2021):

- Strong evidence supports fluoroscopically guided epidural injections with or without steroids for caudal epidural injections, lumbar interlaminar and transforaminal injections, and cervical interlaminar epidural injections for

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cases of disc herniation.
- There is fair to moderate evidence to support the use of thoracic epidural injections for treatment of thoracic disc herniation.
- Some evidence supports lumbar and cervical interlaminar and lumbar transforaminal epidural injections for treatment in the presence of spinal stenosis or axial discogenic pain without facet joint pain; however, the body of evidence is smaller and of lower quality than in the case of disc herniation.

The ASIPP guidelines also provide frequency and location recommendations, including a limit of 2 diagnostic procedures per region at least 2 weeks apart (preferably 4-6 weeks depending upon the steroid used) and a limit of 4 injections per region per year, where cervical and thoracic regions are considered as one region (Manchikanti et al. 2021).

The **ASIPP** also published the following regarding *Facet Joint Interventions in the Management of Chronic Spinal Pain* (Manchikanti et al. 2020):
- **Lumbar Spine:** For diagnostic injections, the level of evidence is I to II with moderate to strong strength of recommendation for diagnostic facet joint nerve blocks. For therapeutic intraarticular injections, the level of evidence is IV with a weak strength of recommendation, based on 9 RCTs which showed an overall lack of efficacy. For therapeutic MBBs, the level of evidence is II with a moderate strength of recommendation based on 3 RCTs. For RFA, the level of evidence is II with a moderate strength of recommendation based 11 RCTs.
- **Cervical Spine:** For diagnostic injections, the level of evidence is II with moderate strength of recommendation. For therapeutic intraarticular injections, the level of evidence is V with a weak strength of recommendation, based on 3 RCTs and 2 observational studies which showed lack of efficacy and durability. For therapeutic MBBs, the level of evidence is II with a moderate strength of recommendation based on 1 RCT and 3 observational studies. For RFA, the level of evidence is II with a moderate strength of recommendation based on 1 RCT and 2 observational studies.
- **Thoracic Spine**: For diagnostic injections, the level of evidence is II with moderate strength of recommendation. For therapeutic intraarticular injections the level of evidence is III with a weak to moderate strength of recommendation. For therapeutic MBBs, the level of evidence is II with a moderate strength of recommendation. For RFA, the level of evidence is III with a weak to moderate strength of recommendation, based on emerging evidence for the thoracic spine which includes 1 RCT and 3 observational studies.

The **American Society of Pain and Neuroscience (ASPN)** published an *Evidence-Based Clinical Guideline of Interventional Treatments for Low Back Pain*. The ASPN recommends the following (Sayed et al. 2022):
- Intraarticular facet steroid injections and lumbar MBBs can be prognostic for RFA, but injections do not replace or delay the need for RFA (Grade C recommendation with a strong level of certainty of net benefit).
- Do not use intraarticular facet joint steroid injections as a sole therapy for facet-mediated pain (Grade B recommendation with a strong level of certainty of net benefit).
- Image-guided facet injections are more effective than blind injections (Grade A recommendation with a strong level of certainty of net benefit).

The **North American Spine Society (NASS)**, in the *Evidence-Based Clinical Guidelines for Multidisciplinary Spine Care: Diagnosis and Treatment of Low Back Pain*, assigned a grade of C to the following recommendations, indicating poor quality evidence (Level IV or V studies) for or against recommending intervention (NASS 2020):
- Intraarticular SIJ injections with steroid may be considered in patients with suspected SIJ pain, and
- CRFA of the sacral lateral branch nerves and dorsal ramus of L5 may be considered in patients with sacroiliac joint pain diagnosed with dual diagnostic blocks.

The **NASS** published coverage policy recommendations for *Epidural Steroid Injections and Selective Spinal Nerve Blocks*. Regarding imaging, every approach, whether transforaminal, interlaminar, or caudal, requires the use of fluoroscopic or CT guidance to enhance safety and efficacy. Insufficient safety and efficacy data exist around ultrasound guidance for any approach to deliver an ESI. For therapeutic ESIs, NASS recommends a pain duration of at least 4 weeks refractory to noninvasive care and that is severe enough to cause a degree of functional impairment. Both ESIs and SSNBs are contraindicated for axial or nonspecific, non-radiating pain, cancer, localized or significant systemic infection, or compressive lesions of the spinal cord (e.g., myelopathy, conus medullaris, cauda equina). The suggested frequency is no more than 6 ESIs and/or SSNBs per 12-month period (regardless of the number of levels involved), no more than 2 transforaminal ESIs at a single setting, and no more than 1 caudal or intralaminar ESI per

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session. Injections should be performed "independently based on the patient's symptoms and response to prior injections and approach," and there is no basis for a "series of 3" ESIs planned in advance (NASS 2020).

The **NASS** published cover policy recommendations for *Facet Joint Interventions*. Image guidance is considered mandatory for successful needle placement and the vast majority of studies have used fluoroscopy. While ultrasound is increasing in popularity, particularly in the cervical spine, NASS considers the use of ultrasound to perform any of these procedures as experimental. The NASS notes that MBBs are a validated means to diagnose facet joint-related pain, and that the primary utility of a MBB is to determine the appropriateness of RFA in order to achieve long-term pain management. When properly conducted, a MBB will anesthetize the intra-articular surfaces, the joint capsule, and the adjacent tissues including the paravertebral muscle. Unlike MBBs, intraarticular injections have not been validated to diagnose facet-joint pain and should generally not be used as a diagnostic test unless a MBB cannot be performed due to anatomic restrictions, as they are only capable of blocking the articular joint surfaces and interior capsules. Dual blocks or intraarticular injections are necessary to confirm the diagnosis due to the high false positive rates of single diagnostic anesthetic injections in the spine. A second, confirmatory injection is indicated only if the first injection(s) produces $\geq$ 80% pain relief of the primary index pain and when the onset and duration of relief is consistent with the agent used (NASS 2016).

SUPPLEMENTAL INFORMATION

The Numeric Rating Scale (NRS-11): Rating Pain Level
0: No Pain
1 – 3: Mild Pain (nagging, annoying, interfering little with ADLs)
4 – 6: Moderate Pain (interferes significantly with ADLs)
7 – 10: Severe Pain (disabling; unable to perform ADLs)

CODING & BILLING INFORMATION

CPT (Current Procedural Terminology)

Code	Description
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed
62320	Injection(s), of diagnostic or therapeutic substance(s) (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
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)
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography)
64479	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level
64480	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
64483	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level

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64484	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)
64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)
64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)
64999	Unlisted procedure, nervous system
0213T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; single level
0214T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; second level (List separately in addition to code for primary procedure)
0215T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)
0216T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; single level
0217T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; second level (List separately in addition to code for primary procedure)
0218T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)

HCPCS (Healthcare Common Procedure Coding System)

Code	Description
G0260	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography

CODING DISCLAIMER. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

APPROVAL HISTORY

04/08/2026 Policy revised. Changed NRS threshold for chronic pain to ≥6 for facet injections/MBBs. Removed required criterion for imaging guidance (fluoroscopy or CT) for SIJ injection types. Removed general or relative contraindications. IRO peer reviewed on March 12, 2026 by a practicing physician board certified in pain management.

12/10/2025 Policy revised. Removed weekly PT requirements and lowered PT minimum to 8 sessions. Added SIJ provocation tests to physical

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exam requirements. Annual review remains in April 2026.

04/09/2025 New policy due to combination of MCP 030 Facet Joint Diagnostic Injections for Chronic Back Pain, MCP 032 Epidural Steroid Injections for Back and Neck Pain, MCP 033 Sacroiliac Injections and RFA for SIJ Pain, and MCP 366 Cluneal Nerve Block for Low Back Pain policies. IRO peer review on April 4, 2025, by a practicing physician board certified in anesthesiology and pain management.

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