Policy Number	**SUR702.015**
Policy Effective Date	**01/01/2026**

Facet Joint Injections

Table of Contents

Related Policies (if applicable)
SUR702.017: Facet Joint and Sacroiliac Joint Denervation

Disclaimer

Carefully check state regulations and/or the member contract.
Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Coverage

Facet joint injections that are performed under fluoroscopic or computerized tomography (CT) guidance **may be considered medically necessary** when the following criteria are met:

- Cervical or lumbar pain consistent with facet joint pain referral pattern (**see NOTE 1**); **AND**
- Failure of at least 4 weeks of noninvasive care (e.g., physical and/or chiropractic therapy, oral analgesia and/or steroids and/or relaxants, activity modification) (**see NOTE 2**); **AND**
- Predominantly axial pain that is not attributable to radiculopathy (**see NOTE 2**) or myelopathy; **AND**
- Clinical assessment implicates the facet joint as the presumed source of pain; **AND**
- Absence of other significant pathology that could explain the source of the patient's pain, such as fracture, tumor, infection, or significant extraspinal lesion.

NOTE 1: The pain referral patterns of the cervical facet joints can include pain in the neck, and/or the head, and/or the periscapular and shoulder region. The pain referral patterns of the lumbar facet joints can include pain in the back, gluteal area and leg.

NOTE 2: The majority of back and neck pain will improve over 4 weeks. It is therefore reasonable to recommend failure of 4 weeks of nonsurgical, noninvasive care. Appropriate nonsurgical, non-injection treatments should be considered along with a rationale for interventional treatment. Exceptions to waiting 4 weeks can exist but should be carefully documented and should be reviewed on a case-by-case basis. These include but are not limited to:

- At least moderate pain with significant functional loss at work and/or home.
- Severe pain unresponsive to outpatient medical management.
- Inability to tolerate nonsurgical, non-injection care due to coexisting medical condition(s) (e.g., cardiac disease).
- Prior successful injections for the same condition.
- The presence of a facet synovial cyst causing nerve root compression with moderate-severe radicular pain and associated functional limitations.

DIAGNOSTIC PHASE (to determine origin of patient's pain)

Facet Joint Medial Branch Blocks (MBB)

- Dual blocks, performed in the same location(s) on 2 separate occasions, are necessary to confirm the diagnosis due to the unacceptably high false positive rate of single diagnostic anesthetic injections in the spine (**see NOTE 3**).
- A second confirmatory injection is indicated only if the first injection produces ≥80% relief of the primary (index) pain and the onset and minimum duration of relief is consistent with the agent employed. This confirmatory block confirms the tested joint as the source if the index pain is reduced by >80%.
- A second injection may also be performed at a different or additional level if the pain is believed to be arising from a different joint (and the pain relief from the initial block was <80%).

NOTE 3: Injections involving the facet joints can be indicated for diagnostic or therapeutic purposes. Therapeutic injections typically involve administration of corticosteroids, with or without local anesthetics, while diagnostic injections use anesthetic alone.

Intraarticular (IA) Facet Joint Injections (**see NOTE 4**)

- Dual IA injections are necessary to confirm the diagnose pain due to the unacceptably high false positive rate of single diagnostic injections in the spine.
- A second confirmatory injection is indicated only if the first injection produced ≥80% relief of the primary (index) pain and the onset and minimum duration of relief is consistent with the agent employed.

NOTE 4: Unlike MBBs, IA facet joint injections have not been validated as a means to diagnose facet joint related pain and should generally not be used in lieu of MBBs for the diagnosis of suspected facet joint pain. IA anesthetic injections are capable of blocking only the articular joint surfaces and interior joint capsule. IA facet joint blocks should not be used as a diagnostic test unless MBBs cannot be performed due to specific documented anatomic restrictions. For

example, in the case of the occipitoatlantal and atlantoaxial joints, there is no medial branch or other innervation available to block reliably, so IA injections are the only means of arriving at a potential diagnosis of pain from these joints.

THERAPEUTIC PHASE (after the diagnostic phase is completed)
Intraarticular Facet Joint Injections

- Therapeutic IA facet joint injections should be repeated no more than three times annually and only if the initial injection results in significant pain relief (>50%) for at least 3 months.

Intraarticular Facet Joint Injections—Synovial Cysts

- Therapeutic facet joint injections for the treatment of facet joint synovial cysts with IA facet joint aspiration/injection/rupture or direct puncture **(see NOTE 5) may be considered medically necessary** when the following criteria are met:
  - Evidence of nerve root compression due to a facet synovial cyst; **AND**
  - Associated moderate-to-severe radicular pain and functional limitations.

NOTE 5: The procedure should not be repeated more than two times on the same joint annually and only if the initial procedure results in significant pain relief (>50%) for at least three months.

Facet injections **are considered not medically necessary** for the following:

- When the above criteria are not met; **OR**
- Additional therapeutic IA facet injections in the absence of an improvement in pain or function; **OR**
- Therapeutic facet IA injections more frequently than every three (3) months; **OR**
- Therapeutic facet IA injections more frequently than four (4) times per year; **OR**
- Therapeutic facet IA injections for the treatment of facet synovial cysts more frequently than two (2) times per year; **OR**
- Therapeutic medial branch blocks.

Ultrasound (US) guidance of either facet or transforaminal injections **is considered experimental, investigational and/or unproven.**

Policy Guidelines

None.

Description

Back pain is one of most common reasons people see a doctor or miss days at work. Most occurrences of low back pain go away within a few days; others may take much longer to resolve or may lead to more serious conditions. Acute, or short-term back pain lasts a few days to a few weeks. Most low back pain is acute. It tends to resolve on its own within a few days

with self-care and there is no residual loss of function. In some cases, a few months are required for the symptoms to disappear. Chronic back pain is defined as pain that continues for 12 weeks or longer, even after an initial injury or underlying cause of acute low back pain has been treated. About 20 percent of people affected by acute low back pain develop chronic low back pain with persistent symptoms at one year. Even if pain persists, it does not always mean there is a medically serious underlying cause or one that can be easily identified and treated. In some cases, 2 treatments successfully relieve chronic low back pain, but in other cases pain continues despite medical and surgical treatment. (1)

Facet joints, also called zygapophysial or "Z" joints, are located on the posterior spine on each side of each vertebra, where they overlap the neighboring vertebrae. The facet joints provide stability and give the spine the ability to bend and twist. Facet joint stimulation comes from the medial branch of the posterior ramus of the spinal nerve. With each facet joint, sensory information is provided through dual stimulation from the spinal nerve at the same level and one level above. (2) A facet joint injection is an injection of a long-acting local anesthetic agent and/or steroid into the facet joint or medial branch nerve or facet joint nerve under image guidance with fluoroscopy or computed tomography (CT). When optimally performed, the injection is made directly into the joint space, though for generations anesthesiologists have been successful in injecting around the joint. Pain relief following a precise intra-articular injection confirms the facet joint as the source of pain.

Cysts can arise from the facet joints, primarily in the lumbar spine, causing both mechanical and biochemical irritation of the adjacent nerves. (3) These cysts typically can be histologically divided into synovial and ganglion cysts. Ganglion cysts, the less common of the two, lack a synovial lining, are typically multiloculated and do not communicate with the adjacent facet joint. Synovial cysts, which represent about 75% of facet joint cysts, have a synovial lining and communicate with the facet joint, making them amenable to fluoroscopic visualization and rupture though needle entry into the facet joint. Facet joint injection and cyst rupture is performed to treat not only the facet joint arthropathy and associated pain but also is performed to rupture the associated facet cyst, thereby decompressing the nerve root in an attempt to avoid the need for a more invasive, open surgical decompression.

Facet joint injections may be indicated for diagnosing facet joint pain, or as a therapeutic intervention to treat facet joint pain. (3) Diagnostic injections with a local anesthetic are used in different regions of the spine to verify the specific area generating pain prior to a facet joint denervation procedure or other medical management. Therapeutic facet joint injections are based on the outcome of a diagnostic facet joint injection with the patient obtaining sufficient relief for a meaningful period of time.

Rationale

This policy is based on a review of coverage guidance from the North American Spine Society (NASS).

Facet Joint Injections (3)

Diagnostic

There are no valid historical physical exam findings, imaging studies or tissue examinations that can identify the cervical facets joints as the source of a patient's neck pain, headaches or shoulder girdle pain. The rationale for using diagnostic cervical medial branch blocks (MBBs) is that pain relief during the anesthetic nerve block provides sufficient evidence that the patient's pain is caused by structures innervated by the target nerves. The primary indication for diagnostic cervical MBBs is to determine the suitability of the patient for a radiofrequency neurotomy of the painful segmental level(s) identified by the diagnostic MBBs, in order to achieve long-term management of the patient's pain.

Since there is evidence of a significant false positive rate for diagnostic cervical medial branch blocks, dual confirmatory (or "comparative") blocks with local anesthetics of different expected durations of effect, administered on two separate occasions, are recommended to decrease the rate of false positive results. However, the increased specificity afforded by comparative blocks comes at the cost of decreased sensitivity, meaning that the number of false negative patients will increase, meaning some will be disqualified from potentially effective treatment.

Cervical intraarticular (IA) facet joint injections have not been validated for diagnostic use. Thus, their false positive rate is not known. Lacking validity, they have limited utility in the diagnosis of Z-joint pain. There have been no studies that compare the effectiveness of IA facet joint injections vs. MBBs in the cervical spine. The use of diagnostic IA injections is thus reserved for those cases where MBBs are not anatomically possible, as is the case with occipitoatlantal and atlantoaxial joints.

Image guidance is considered mandatory for successful needle placement for both IA and MBBs. The vast majority of studies have used fluoroscopy during needle placement. Ultrasound is experiencing increasing popularity in the cervical spine due to the proximity of the target structures to the skin and thus the ability to visualize these structures. Currently, the use of ultrasound to perform any of these procedures is considered experimental, and coverage is not recommended at this time. Computed tomography guidance has also been used to direct needle placement, particularly for intraarticular injections.

Therapeutic

Corticosteroid injections for painful joint conditions outside the spine are a common practice, yet evidence is lacking for therapeutic joint injections–both within and outside the spine. Therapeutic use of IA facet joint injections is largely based on limited case series and anecdotes, with conflicting results. In controlled trials, benefits relative to other treatments are observed in some, but others fail to show significant short- or long-term benefits. The negative trial, however, studied only patients with chronic pain following a whiplash injury, so it is unknown if similar results will occur when treating acute pain or pain related to inflammatory joint conditions. Currently there is minimal to no evidence to support the use of therapeutic IA facet joint injections in the management of chronic neck pain.

The use of intraarticular injections for aspiration, steroid injection and rupture of synovial cysts arising from the lumbar facet joints is well described. These procedures are typically accompanied by transforaminal epidural steroid injections to treat the radicular pain component. However, the use of these procedures does not produce universally excellent results, and the cysts return about half of the time, necessitating the need for surgical consideration.

The rationale behind therapeutic MBBs is that that compression or inflammation of the medial branch nerve may be responsible for facet joint related pain or that injections of anesthetic and other potentially therapeutic substances may cause local nerve or central nervous system changes in pain transmission. However, these suggested mechanisms have never been demonstrated empirically.

Prospective randomized studies of therapeutic MBBs compared the standard anesthetic MBBs with blocks combining anesthetics and corticosteroids, showing no differences between groups in terms of pain relief, function, or number of required injection treatments. In these studies, patients in each group received an average of 4-5 injections per year for diagnosis and treatment.

Therapeutic cervical medial branch blocks showed short-term relief in an initial small case series published in 1986. Since then, nearly all research on therapeutic MBBs has come from a single center and includes a prospective case series and publications from a randomized controlled trial. The outcomes documented in these studies involve patients who received between 4-5 injections in the first year of the trial. The repeated treatments were performed at various unspecified intervals, without reporting their timing relative to outcomes collection. Thus, it is impossible to determine the true duration of treatment effect. Furthermore, the publications from the randomized trail reveal no additional benefits when other potentially therapeutic medications, such as corticosteroids, are added to traditional anesthetic MBBs.

There are no studies that have compared the effectiveness of therapeutic MBBs injections with medial branch radiofrequency neurotomy, a treatment known to provide effective long-term management of cervical facet joint pain. Only one study has compared therapeutic MBBs to any other treatment, and this was in the lumbar spine. In this prospective, blinded, randomized trial patients were treated with the same combination of corticosteroids and anesthetics with MBBs vs. IA facet joint injections. Statistically significant and clinically relevant improvements were observed in IA facet joint injection group relative to the therapeutic MBB group.

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	64490, 64491, 64492, 64493, 64494, 64495, 77003, 0213T, 0214T, 0215T, 0216T, 0217T, 0218T
HCPCS Codes	None

*Current Procedural Terminology (CPT®) ©2024 American Medical Association: Chicago, IL.

References

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2. Le DT, Alem N. Facet Joint Injection. [Updated 2023 Jun 20]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 January. Available at <https://www.ncbi.nlm.nih.gov> (accessed November 18, 2025).
3. North American Spine Society. NASS Coverage Policy Recommendations—Facet Joint Interventions. (October 2016). Available at <https://www.spine.org> (accessed September 12, 2025).

Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does not have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been developed since this medical policy document was written. See Medicare's National Coverage at <https://www.cms.hhs.gov>.

Policy History/Revision

Date	Description of Change
01/01/2026	Document updated. The following changes were made to Coverage: Criteria significantly revised to align with specialty society recommendations. Reference 2 added; others removed.
02/01/2025	Reviewed. No changes.
11/01/2023	Document updated with literature review. The following changes were made to Coverage: 1) Diagnostic Phase Section: Added "For each covered spinal region, a maximum of four (4) diagnostic joint sessions per rolling 12

	months, in recognition that the pain generator cannot always be identified with the initial and confirmatory diagnostic procedure" to the criteria and defined pain relief as at least 80% or more relief in primary pain index 2) Therapeutic Phase Section: The first bullet was replaced with "Therapeutic facet joint injection at the same anatomic site for recurrent pain may be repeated if the prior injection provided at least 50% reduction in pain with functional improvement of at least 3 months duration", the second bullet revised to include "a maximum of four (4) therapeutic facet joint (intra-articular [IA]) injection sessions per rolling 12 months", the therapeutic frequency is now limited to every three (3) months per spinal region 3) The facet injections not medically necessary statements revised to state more frequently than "every three (3) months" or "four times" per year per spinal region. Added references 15 and 16; others updated.
1/15/2023	Reviewed. No changes.
9/15/2021	Document updated with literature review. The following changes were made to Coverage: computerized tomography (CT) was added to the facet joint injections medically necessary statement; six weeks for conservative therapy; Some criteria were replaced with 1) Predominant axial pain that is not attributable to radiculopathy (with the exception of synovial cysts, see Therapeutic Phase section below), myelopathy, or neurogenic claudication 2) Physical exam findings which are consistent with the facet joint as the presumed source of pain 3) Absence of non-facet pathology that could explain the source of the patient's pain, such as fracture, tumor, or infection; and Therapeutic facet joint injections when the following criteria are met: Evidence of nerve root compression due to a facet synovial cyst when seen on an advanced imaging study (magnetic resonance imaging [MRI] or CT) performed within the previous 12 months that correlates with the clinical findings; AND Associated moderate-to-severe radicular pain and functional limitations was added to the Therapeutic phase. References 3, 5, 12, and 15 were added and some removed.
3/1/2020	Document updated with literature review. The following change was made: removed wording "radiculopathy has been ruled out by a magnetic resonance imaging (MRI) from the fourth bullet of the first medically necessary coverage statement. References 6 and 14-15 were added.
4/15/2017	Reviewed. No changes.
3/15/2016	Document updated with literature review. Coverage unchanged.
4/15/2015	Reviewed. No changes.
12/15/2014	Document updated with literature review. Coverage unchanged.
7/15/2012	Document updated with literature review. Coverage unchanged.
7/15/2010	Document updated with literature review. CPT/HCPCS code(s) updated. Document number changed from SUR702.015bu. The following was added: Ultrasound guidance of either facet or transforaminal injections is considered experimental, investigational and unproven.

1/15/2010	New medical document; facet joint injections may be considered medically necessary when specific criteria are met.