This Policy applies to all SECUR affiliates, associates, and subsidiaries.

Approved by Courtney Gonzales, Director of Health Services on behalf of the Utilization Management Committee.

PURPOSE

This coverage determination guideline serves to address invasive procedures for back pain.

For SECUR Health Plan members, National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) will be applied to requests when applicable. SECUR Health Plan Coverage Determination Guidelines (CDG) will be utilized in the absence of an appropriate NCD and/or LCD.

DEFINITIONS

None

POLICY

SECUR Health Plan considers any of the following injections or procedures as medically necessary for the treatment of back pain, provided that only one invasive modality or procedure will be considered medically necessary at a time.

1. Facet Joint Injections
   An initial facet injection (intra-articular and medial branch block) from C2-3 to L5-S1 is considered medically necessary for the diagnosis of facet pain in persons with severe chronic neck and back pain when the following criteria are met:
   - i. Member has symptoms suggestive of facet joint syndrome (symptoms of facet joint syndrome include absence of radiculopathy, pain that is aggravated by extension, rotation or lateral bending of the spine and is not typically associated with any neurological deficits); *and*
   - ii. Facet mediated pain is confirmed by provocative testing on physical examination (to confirm that pain is exacerbated by extension and rotation); *and*
   - iii. Imaging studies suggest no other obvious cause of pain (such as fracture, tumor, infection, or significant extraspinal lesion)*; and*
   - iv. Pain limits daily activities; *and*
   - v. Pain has lasted more than 3 months; *and*
   - vi. Pain has persisted despite six or more weeks of conservative treatment (including, systemic medications, and/or physical therapy); *and*
   - vii. Radiofrequency facet neurolysis is being considered.

   Injection of no more than three (3) facet joint levels are considered medically necessary during the same session/procedure. These may be performed bilaterally during the same session for a total of up to six (6) injections. One to 2 levels, either unilateral or bilateral, are allowed per session per spine region. Three or

4 level procedures are not medically necessary and therefore are non-covered. A session is a time period, which includes all procedures (i.e., MBB, IA, facet cyst ruptures, and RFA ablations) that are performed during the same day.
The use of Moderate or Deep Sedation, General Anesthesia, and Monitored Anesthesia Care (MAC) is not considered medically reasonable and necessary during facet injections.

A Second diagnostic facet injection (intraarticular and medial branch block) is considered medically necessary to confirm the validity of the clinical response to the initial facet injection when it is administered at the same level as the initial facet injection, and where the initial facet injection produced a positive response. If the initial injection did not produce a positive response, a second diagnostic injection is considered not medically necessary.

Additional sets of facet injections or medial branch blocks at the same levels and side are considered experimental, investigational, or unproven because they have no proven value.

SECUR Health Plan considers diagnostic facet joint injections not medically necessary where radiofrequency facet neurolysis is not being considered.

Diagnostic facet joint injections are considered experimental, investigational, or unproven for neck and back pain with untreated radiculopathy.

Facet join injections are considered experimental, investigational, or unproven as therapy for back and neck pain and for all other indications because their effectiveness for these indications has not been established. Facet joint injections containing corticosteroids are considered therapeutic injections.

SECUR Health Plan considers ultrasound guidance for facet injections experimental, investigational, or unproven because of a lack of sufficient evidence of the effectiveness.

2. Trigger Point Injections
SECUR Health Plan considers trigger point injections of normal saline, corticosteroids, and/or local anesthetics medically necessary for treatment of members with chronic neck pain, back pain, or myofascial pain syndrome when all of the following criteria are met:
   a. Conservative treatment such as bed rest, exercises, heating or cooling modalities, massage, and pharmacotherapies such as non-steroidal anti-inflammatory drugs (NSAIDS), muscle relaxants, non-narcotic analgesics, should have been tried and failed, *and*
   b. Symptoms have persisted for more than 3 months, *and*
   c. Trigger points have been identified by palpation; *and*
   d. Trigger point injections are not administered in isolation, but are provided as part of a comprehensive pain management program, including physical therapy, patient education, psychosocial support, and oral medication where appropriate.

A trigger point is defined as a specific point or area where if stimulated by touch or pressure, a painful response is induced. A set of trigger point injections means injection in several trigger points in one sitting.

Up to four (4) sets of injections are considered medically necessary to diagnose the origin of a member's pain and achieve a therapeutic effect. Additional sets of trigger point injections are not considered medically necessary if no clinical response is achieved. It is not considered medically necessary to repeat

injections for this indication at a frequency of more than once every seven (7) days.

Once diagnosis has been established and a therapeutic effect achieved, it is rarely considered medically necessary to repeat trigger point injections more frequently than once every two (2) months. Repeated injections extending beyond one year's time, may be reviewed for continued medical necessity.

Trigger point injections are considered experimental, investigational, or unproven for all other indications because their effectiveness for indications other than the ones listed have not been established.

SECUR Health Plan considers ultrasound or electromyography (EMG) guidance of trigger point injections to be experimental, investigational, or unproven because there is insufficient evidence to show effectiveness.

3. Sacroiliac Joint Injections
SECUR Health Plan considers sacroiliac joint injections medically necessary to relieve pain associated with lower lumbosacral disturbances in members who meet all the following criteria:
   a. Member has moderate to severe low back pain primarily experienced over the anatomical location of the sacroiliac joints between the upper level of the iliac crests and the gluteal fold, and
   b. Member has low backpain for greater than 3 months; *and*
   c. Member has pain at or close to the posterior superior iliac spine (PSIS) with possible radiation into buttocks, posterior thigh, or groin and can point to the location of pain (Fortin Finger Test); *and*
   d. Member has at least 3 of 5 physical examination maneuvers specific for SI joint pain:
      i. SI Compression
      ii. Posterior Pelvic Pain Provocation test – P4 (Thigh Thrust)
      iii. Patrick's test (Fabere)
      iv. Sacroiliac distraction test
      v. Yeoman Tests
      vi. Gaenslen's test, and
   e. Other causes of low back pain have been ruled out, including lumbar disc degeneration, lumbar disc herniation, lumbar spondylolisthesis, lumbar spinal stenosis, lumbar facet degeneration, and lumbar vertebral body fracture; *and*
   f. Member has tried four (4) weeks of adequate forms of conservative treatment with little or no response, including pharmacotherapy (e.g., NSAIDS), activity modification, and active therapy (including physical therapy where appropriate); *and*
   g. The injections are not used in isolation, but are provided as part of a comprehensive pain management program, including physical therapy, education, psychosocial support, and oral medication where appropriate.

Up to two (2) therapeutic/diagnostic sacroiliac injections are considered medically necessary to diagnose the member's pain and achieve therapeutic effect. It is not considered medically necessary to repeat these therapeutic/diagnostic injections more frequently than once every seven (7) days.

Additional therapeutic sacroiliac injections are considered medically necessary if the member has improvement in lower back pain numeric rating scale (NRS) of at least 70% of the pre-injection NRS score after fluoroscopic or CT controlled injection of local anesthetic with or without steroid into the affected SI joint. If the member experiences less than 70% reduction of pain for the anticipated duration of the anesthetic, additional sacroiliac joint injections are considered not medically necessary.

Diagnostic Sacroiliac Joint Injections
Diagnostic SIJI is used to determine if the etiology of pain is from the sacroiliac joint complex. SECUR Health Plan will consider diagnostic SIJI as medically necessary when the following are met:

1. Member must meet the above criteria for medical necessity, and
2. SI joint injections must be performed under CT or fluoroscopy image guidance with contrast, except ultrasound guidance may be considered medically necessary when there is a documented contrast allergy or pregnancy, since the accuracy with ultrasound guidance is inferior to fluoroscopic guidance, and
3. SI joint injections are not performed with other musculoskeletal injections in the lumbosacral spine, and
4. Documentation shows direct causal benefit from the SI joint injection and not from other musculoskeletal injections or treatments, and
5. The diagnostic SIJI provided a minimum of 75% relief of primary pain with the diagnostic SIJI was measured by the same pain scale at baseline. The measurements of pain must be taken pre-injection on the say of the SIJ injection, post-intervention on the day of the injection, and the days following the injection to substantiate and corroborate the pain scores consistent with the pain relief for the duration of the local anesthetic and/or steroid used.

No more than two (2) diagnostic joint sessions, unilateral or bilateral will be considered medically necessary. (Two (2) unilateral sessions, if performed on one (1) side at one session and the opposite at a different session would meet the limit of two (2) diagnostic sessions.)

Once diagnosis is established, up to four (4) therapeutic sacroiliac injections, repeated no more than once every seven (7) days, are considered medically necessary every twelve (12) months.

Ultrasound guidance of sacroiliac joint injections is considered not medically necessary.

Sacroiliac joint injections are considered experimental, investigational, or unproven for all other indications because their effectiveness for other indications has not been established.

4. Interlaminar Epidural Injections
SECUR Health Plan considers interlaminar epidural injections of corticosteroid preparations, with or without added anesthetic agents, medically necessary for the following:
   a. In the outpatient setting for management of members with radiculopathy or sciatica when all the following criteria are met:
      i. Pain is radicular in nature. In low back pain, radicular means pain and/or numbness that radiates below the knee. In neck pain, it is pain, numbness, and/or weakness in the shoulder, arm, wrist, and/or hand, and
      ii. Intraspinal tumor or other space-occupying lesion or non-spinal origin for pain has been ruled out as the cause of pain. Where indicated for evaluation of lumbar, cervical, or thoracic pain, advanced diagnostic imaging should be performed within 24 months prior to initiating intralaminar epidural injections, and
      iii. Member has failed show improvement after four (4) or more weeks of conservative treatment, and
      iv. Interlaminar epidural injections are provided as part of a comprehensive pain management program, which includes physical therapy, patient education, psychosocial support, and oral medication, where appropriate.
   b. Additional interlaminar epidural injections, if the initial injection resulted in at least two (2) of the

following for at least two (2) weeks:

i. 50% or greater relief in pain, and
ii. Increase in level of function and/or physical activity, and
iii. Reduction in the use of pain medications and/or additional medical services, and
iv. Intralaminar epidural injections are provided as part of a comprehensive pain management program that includes physical therapy, patient education, psychosocial support, and oral medication.

Additional epidural injections are considered not medically necessary if these criteria are not met.

c. No more than one (1) interlaminar epidural injection is considered medically necessary per session. More than one (1) interlaminar epidural injection in a single region per session or of more than one (1) region per session is considered not medically necessary.

Repeated epidural injections more frequently than once every two (2) weeks are not considered medically necessary.

d. A total of up to three (3) interlaminar epidural injections per region, per episode of pain, are considered medically necessary in six (6) months' time, and up to four (4) interlaminar epidural steroid injections per region per rolling 12-month period are considered medically necessary only upon return of pain and/or deterioration in function, and only when responsiveness to prior injections has occurred with at least 50% pain reduction and/or symptoms for at least two (2) weeks.

Additional interlaminar epidural injections per region per rolling 12-month period are considered not medically necessary and experimental, investigational, or unproven because there is no evidence to support this.

SECUR Health Plan considers ultrasound guidance of epidural injections as experimental, investigational, or unproven because of insufficient evidence to show effectiveness.

Interlaminar epidural injections of corticosteroid preparations, with or without added anesthetic agents, are considered experimental, investigational, or unproven for all other indications because their effectiveness for indications other than those listed have not been proven or established.

5. Non-Pulsed Radiofrequency Facet Denervation
SECUR Health Plan considers non-pulsed radiofrequency facet denervation (facet neurotomy, facet rhizotomy, or articular rhizolysis) medically necessary for the treatment of members with intractable cervical or back pain with or without sciatica in the outpatient setting when all the following are met:
   a. Member has experienced severe pain limiting activities of daily living (ADLs) for at least six (6) months, and
   b. Member has had no prior spinal fusion surgery at the level to be treated, and
   c. Neuroradiologic studies are negative or fail to confirm disc herniation, and
   d. Member has no significant narrowing of the vertebral canal or spinal instability requiring surgical intervention, and
   e. Member has tried and failed six (6) or more weeks of conservative treatment, and
   f. Member has had two (2) positive diagnostic facet join injections at the level to be treated, evidenced by at least 80% relief of facet mediated pain for at least the expected minimum duration of the effect of the local anesthetic utilized.

When performing radiofrequency joint denervations/ablations, it may be necessary to perform the procedure at the same level(s) bilaterally; however, radiofrequency ablation of no more than three levels are considered medically necessary during the same session/procedure.

Provided that greater than 50% pain relief is experienced for at least twelve (12) weeks, further facet denervation procedures should be conducted at intervals of at least six (6) months per level per side, at a maximum of twice per rolling calendar year. Only one (1) treatment procedure, per level, per side, is considered medically necessary within a six (6) month period.

Non-pulsed radiofrequency facet denervation is considered experimental, investigational, or unproven for all other indications because effectiveness has not been established.

6. Spinal Fixation
   SECUR Health Plan considers pedicle screws medically necessary for posterior spinal fusion. Use of interspinous or interlaminar distraction or stabilization devices with or without lumbar laminectomy and/or fusion are considered experimental, investigational, or unproven. Additionally, CoFix for interlaminar/interspinous stabilization is considered experimental, investigational, or unproven.

7. Intervertebral Body Fusion Devices
   SECUR Health Plan considers intervertebral body fusion devices (synthetic spine cages/spacers) not medically necessary.

8. Percutaneous Polymethacrylate Vertebroplasty (PPV), Kyphoplasty, or Spinejack System
   SECUR Health Plan considers percutaneous polymethacrylate vertebroplasty, kyphoplasty, and Spinejack System medically necessary for members with persistent, debilitating pain in the thoracic or lumbar vertebral bodies resulting from any of the following:

   a. Multiple myeloma; *or*
   b. Painful and/or aggressive hemangiomas; *or*
   c. Painful vertebral eosinophilic granuloma; *or*
   d. Painful, debilitating osteoporotic acute or subacute collapse/compression fractures (proven not to be chronic on recent imaging); *or*
   e. Primary malignant neoplasm of bone or bone marrow; *or*
   f. Secondary osteolytic metastasis, excluding sacrum and coccyx, but including cervical;

   And when all the following criteria are met:

   a. The pain is localized to the level of the pathology being treated; *and*
   b. Other causes of pain such as spinal stenosis or herniated intervertebral disk have been ruled out by computed tomography or magnetic resonance imaging; *and*
   c. The affected vertebra has not been extensively destroyed and is at least 1/3 of its original height with intact posterior cortex; *and*
   d. Painful, debilitating osteoporotic acute or subacute collapse/compression fractures, proven not to be chronic based on recent imaging:

      i. The impacted vertebra has at least 25% (1/4) height loss/compression, but not been extensively destroyed and is at least 1/3 of original height with intact posterior cortex, and
      ii. Maximum of three (3) vertebral fractures per procedure, and

iii. Severe debilitating pain or loss of mobility that cannot be relieved by a minimum of six (6) weeks of optimal non-invasive therapy that includes physical therapy, bracing, and/or oral medication, and
iv. Documentation for continuum of care for an evaluation of bone mineral density and osteoporosis education for subsequent treatment as indicated and instructed to take part in an osteoporosis prevention and/or treatment program

9. Lateral Interbody Fusion (including extreme XLIF, extra and direct lateral DLIF)

SECUR Health Plan considers XLIF and DLIF as an acceptable method of performing medically necessary anterior interbody fusion.

10. Percutaneous Image-Guided Lumbar Decompression (PILD) for Spinal Stenosis

Percutaneous Image-Guided Lumbar Decompression is considered medically necessary for members who are enrolled in an approved clinical study that meets the Medicare approved criteria for a clinical study of PILD based on section 1862(a)(1)(E) of the Social Security Act for members with lumbar spinal stenosis.

11. Coccygectomy

SECUR Health Plan considers coccygectomy medically necessary for individuals with coccygodynia who have tried and failed to respond positively to six (6) months of conservative management.

12. Cementoplasty

SECUR Health Plan considers cementoplasty medically necessary for members with bone pain from pelvic bone metastases with decreased mobility and who have failed conventional pain treatments.

13. Sacroiliac Joint Fusion

SECUR Health Plan considers minimally invasive arthrodesis of the sacroiliac joint medically necessary for sacroiliac joint syndrome interfering with activities of daily living (ADLs) when all the following criteria are met:

a. Member has experienced sacroiliac joint pain for greater than six (6) months, and
b. Diagnosis of the SI joint as the primary pain generator based on all the following:

i. Member has pain at or close to the posterior superior iliac spine with possible radiation into the buttocks, posterior thigh region, or groin and can point to the location of the pain (Fortin Finger Test), and
ii. Member has at least three (3) out of five (5) physical exam maneuvers specific for SI join pain including compression, posterior pelvic pain provocation test – P4 (thigh thrust), Patrick's test (Fabere), sacroiliac distraction test, and/or Gaenslen's test, and
iii. Other causes of the pain have been ruled out, and
iv. Sacroiliac pathology is not caused by an autoimmune disease, and/or
v. Member has improvement in lower back pain with numeric rating scale (NRS) of at least 70% of the pre-injection NRS score after two (2) separate fluoroscopic or CT controlled injections of local anesthetic into the affected SI joint within the past year, and

c. Baseline lower back pain score of at least five (5) on a 0-10 point NRS, and
d. Member has tried six (6) months of adequate forms of conservative treatment with little or no response including pharmacotherapy, activity modification, and at least three (3) months of formal in-person physical therapy in the past year, and
e. Radiologic evidence exists on imaging of SI joint degeneration, and
f. Member is nicotine-free for at least one (1) year prior to surgery. In those with recent nicotine use, documented nicotine cessation should include a formal lab report showing blood and urine nicotine levels less than or equal to 10 ng/ml and must be drawn within six (6) weeks of surgery.

Open sacroiliac joint fusion is considered medically necessary for SI joint infection, tumors involving the sacrum, and SI pain due to severe traumatic injury where a trial of an external fixator is successful in pain relief.

SI joint fusions are considered experimental, investigational, or unproven for all other indications because their effectiveness has not been established.

14. The Spinal System-X (Corus) is a supply and not an implant and is covered as part of the global surgical fee and is not separately reimbursable.

SECUR Health Plan considers the following (not an all inclusive list) as experimental, investigational, or unproven due to insufficient evidence to support effectiveness.

- ccuraScope procedure;
- AnchorKnot Tissue Approximation Kit (Anchor Orthopedics) for lumbar discectomy;
- Annulus repair devices (Xclose Tissue Repair System, Barricaid, Disc Annular Repair Technology (DART) System);
- BacFast HD for isolated facet fusion;
- Biomet Aspen fusion system (an interlaminar fixation device);
- Chemical ablation (including but not limited to alcohol, phenol, or sodium morrhuate) of facet joints;
- Chymopapain chemonucleolysis, for all indications;
- Coccygeal ganglion (ganglion impar) block for coccydynia, pelvic pain, and all other indications;
- Cooled radiofrequency ablation (e.g., Coolief) for facet denervation;
- Cryoablation (cryoanesthesia, cryodenervation, cryoneurolysis, or cryosurgery) for the treatment of lumbar facet joint pain;
- Deuk Laser Disc Repair;
- Devices for annular repair (e.g., Inclose Surgical Mesh System);
- Direct visual rhizotomy (extradural transection or avulsion of other spinal nerve) for the treatment of chronic low back pain;
- DiscoGel (intradiscal alcohol injection) for the treatment of back and neck pain;
- Discseel procedure (regenerative spine procedure) for the treatment of back pain;
- Dynamic (intervertebral) stabilization (e.g., BioFlex, CD Horizon Agile Dynamic Stabilization Device, DSS Dynamic Soft Stabilization System, Dynabolt Dynamic Stabilization System, Dynesys Spinal System, Graf ligamentoplasty/Graf artificial ligament, Isobar Spinal System, NFix, Satellite Spinal System, Stabilimax NZ Dynamic Spine Stabilization System, and the Zodiak DynaMo System);
- Endoscopic disc decompression, ablation, or annular modulation using the DiscFX System;
- Endoscopic laser foraminoplasty, endoscopic foraminotomy, laminotomy, and rhizotomy (endoscopic radiofrequency ablation);
- Endoscopic transforaminal diskectomy;

- Epidural fat grafting during lumbar decompression laminectomy/discectomy;
- Epidural injections of lytic agents (e.g., hyaluronidase, hypertonic saline) or mechanical lysis in the treatment of adhesive arachnoiditis, epidural fibrosis, failed back syndrome, or other indications;
- Epidural steroid injections for the treatment of non-radicular low back pain;
- Epiduroscopy (also known as epidural myeloscopy, epidural spinal endoscopy, myeloscopy, and spinal endoscopy) for the diagnosis and treatment of intractable LBP or other indications;
- Facet chemodenervation/chemical facet neurolysis;
- Facet joint allograft implants (NuFix facet fusion, TruFuse facet fusion)
- Facet joint implantation (Total Posterior-element System (TOPS) (Premia Spine), Total Facet Arthroplasty System (TFAS) (Archus Orthopedics), ACADIA Facet Replacement System (Facet Solutions/Globus Medical);
- Far lateral microendoscopic diskectomy (FLMED) for extra-foraminal lumbar disc herniations or other indications;
- Fluoroscopic guidance for trigger point injection;
- Hardware injections/blocks;
- Injection of steroid into the ilio-lumbar ligament for the treatment of low back pain (LBP);
- Interlaminar lumbar instrumented fusion (ILIF);
- Interspinous and interlaminar distraction devices;
- Interspinous fixation devices (Benefix Interspinous Fixation System, CD HORIZON SPIRE Plate, PrimaLOK SP, SP-Fix Spinous Process Fixation Plate, and Stabilink interspinous fixation device) for spinal stenosis or other indications;
- ntracept System (intra-osseous basivertebral nerve ablation) for the treatment of low back pain, and neck pain;
- Intradiscal injections of notochordal cell-derived matrix for the treatment of intervertebral disc disease;
- Intradiscal injection of platelet-rich plasma;
- Intradiscal, paravertebral, or epidural oxygen or ozone injections;
- Intradiscal steroid injections;
- Intramuscular steroid injection for the treatment of back pain, neck pain
- Intravenous administration of corticosteroids, lidocaine, magnesium, or vitamin B12 (cyanocobalamin) as a treatment for back pain and neck pain;
- ION procedure (Ion Facet Screw System);
- Khan kinetic treatment (KKT);
- Laser facet denervation;
- Least invasive lumbar decompression interbody fusion (LINDIF);
- Magnetic resonance imaging-guided focused ultrasound (MRgFUS) for the treatment of lumbar facet joint pain;
- Microendoscopic discectomy (MED; same as lumbar endoscopic discectomy utilizing microscope) procedure for decompression of lumbar spine stenosis, lumbar disc herniation, or other indications;
- Microsurgical anterior foraminotomy for cervical spondylotic myelopathy or other indications;
- Minimally invasive/endoscopic cervical laminoforaminotomy for cervical radiculopathy/lateral and foraminal cervical disc herniations or other indications;
- Minimally invasive lumbar decompression (MILD) procedure (percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements under indirect image guidance) for lumbar canal stenosis or other indications;
- Minimally invasive thoracic discectomy for the treatment of back pain;
- Minimally invasive *endoscopic* transforaminal lumbar interbody fusion (endoscopic MITLIF; same as endoscopic MAST fusion) for lumbar disc degeneration and instability or other indications;
- OptiMesh grafting system;

- Percutaneous cervical and lumbar diskectomy;
- Percutaneous endoscopic diskectomy with or without laser (PELD) (also known as arthroscopic microdiskectomy or Yeung Endoscopic Spinal Surgery System [Y.E.S.S.]);
- Percutaneous lumbar discectomy (manual or automated) for treatment of degenerative disc disease;
- Piriformis muscle resection and other surgery for piriformis syndrome;
- Platelet-rich plasma for facet joint injections;
- Posterior intrafacet implants (e.g., DTRAX Cervical Cage) for posterior cervical fusion;
- Psoas compartment block for lumbar radiculopathy or myositis ossification;
- Puborectalis and iliococcygeus trigger point injections for the treatment of pelvic pain;
- Racz procedure (epidural adhesiolysis with the Racz catheter) for the treatment of members with adhesive arachnoiditis, epidural adhesions, failed back syndrome from multiple previous surgeries for herniated lumbar disk, or other indications;
- Radiofrequency denervation for sacroiliac joint pain;
- Radiofrequency lesioning of dorsal root ganglia for back pain;
- Radiofrequency lesioning of terminal (peripheral) nerve endings for back pain;
- Radiofrequency/pulsed radiofrequency ablation of trigger point pain;
- Sacroiliac ligament injection for the treatment of unspecified dorsalgia;
- Sacroplasty for osteoporotic sacral insufficiency fractures and other indications;
- Tendon and/or tendon sheath injections for the spine;
- Tendon sheath injections for the treatment of back pain;
- Therapeutic facet joint injections;
- Total Facet Arthroplasty System (TFAS) for the treatment of spinal stenosis;
- Ultrasound guidance of epidural injections;
- Ultrasound guidance of facet injections;
- Ultrasound or electromyography (EMG) guidance of trigger point injections;
- Vesselplasty (e.g., Vessel-X).

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