



MEDICAL POLICY STATEMENT

Original Effective Date	Next Annual Review Date	Last Review / Revision Date
01/27/2015	01/27/2016	01/27/2015
Policy Name	Policy Number	
Facet Neurotomy	MM-0009	

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

For Medicare plans please reference the below link to search for Applicable National Coverage Descriptions (NCD) and Local Coverage Descriptions (LCD):

A. SUBJECT

Facet Neurotomy

B. BACKGROUND

After a successful diagnostic facet medial nerve block injection, available interventional options to help manage pain in selected patients may include a facet neurotomy which ablates the nerve.

A presumptive diagnosis of facet joint pain is made clinically. This may be confirmed by relief of pain through Diagnostic Medial Branch Nerve Block, an injection of local anesthetic to the medial branches of the posterior rami of the dorsal spinal nerves supplying the proposed facet joint(s).[1-3] In the therapeutic phase after positive diagnostic block, a successful radiofrequency facet neurotomy of the affected (same anatomic location of the positive diagnostic block) nerve may relieve pain for a period of months to a year or more until nerve regeneration occurs.[1, 4]

Interventional procedures for management of pain should be part of a comprehensive pain management care plan that incorporates an initial trial of conservative treatment utilizing appropriate medications, physical therapy modalities and behavioral support as needed. Interventional procedures for the management of pain unresponsive to conservative treatment should be provided only by physicians qualified to deliver these health services.[1, 5, 6]

C. DEFINITIONS

None

D. POLICY

Criteria

Evidence for **cervical spine facet neurotomy** is Level II-1 [7] (criteria as described by the Agency for Healthcare Research and Quality [AHRQ] and the US Preventative Services Task Force [USPSTF] [8, 9]). The average duration of pain relief greater than 50% from baseline is 7 to 9 months after initial cervical facet neurotomy. If indicated, repeat cervical facet neurotomy is



successful 67% to 95% of the time.[10] Evidence for **lumbar spine facet neurotomy** is Level II-2 with favorable results at less than 6 months post-procedure.[7] The average pain relief greater than 50% from baseline is 9 months after initial lumbar facet neurotomy. If indicated, repeat lumbar facet neurotomy is successful 33% to 85% of the time, with subsequent relief enduring for an average of 12 months.[10]

If requested a repeat neurotomy in the same spine region requires that 50% or greater relief by pain score is obtained for a minimum of 3 months after the prior neurotomy (maximum of 2 neurotomies per rolling 12 months). In the diagnostic phase, a patient receives injection of local anesthetic to identify the pain generator with an appropriate clinical response in reduction of pain and improvement in physical exam findings.[1, 11]

CareSource will consider a Facet Medial Branch Neurotomy medically necessary for treatment of sub-acute non-radiating pain that is unresponsive to a well-managed course of conservative therapy when the following criteria exist:

- A thorough history and physical exam documenting cause of the pain if known, duration of symptoms, severity, exacerbating factors, abnormal physical and diagnostic findings and prior conservative treatment measures.
- Documentation of associated medical and psychological disorders
- Diagnostic studies including x-rays and MRIs where appropriate that have confirmed the diagnosis of facet arthropathy or degenerative disease of the spine.
- Successful diagnostic facet medial branch nerve block for the same symptoms, signs, and anatomic location.

The evidence for cervical spine facet medial branch nerve block injections is fair.[12, 13] Available literature for thoracic spine facet medial branch nerve block injections shows Level II scientific evidence (criteria as described by the Agency for Healthcare Research and Quality [AHRQ] and the US Preventative Services Task Force [USPSTF] [8, 9]) for diagnostic accuracy in 3 studies with a total of less than 200 subjects. For therapeutic injections 3 reports exist with 76% to 90% achieving relief at 12 months, but without placebo controls.[14-16] Evidence is Level I or II-1 for diagnostic lumbar facet medial branch nerve block injections and [7, 17] and good for therapeutic lumbar facet medial branch nerve block injections in 11 randomized trials.[18, 19]

Prior to interventions, imaging studies rule out other causes of spinal pain (examples include herniated disc, spinal stenosis, fracture or tumor). These imaging studies are completed within the 12 months prior to the date of the request for interventions. The treating physician should also verify that the patient has no blood clotting defect, is not on blood thinner medication, and does not have any infection.

Facet neurotomy should be performed with imaging guidance. Image guidance and any injection of contrast are inclusive components of CPT codes 64490-64495. Monitored anesthesia care is not necessary for pain management injections and is not covered for payment when performed during these services. If chosen to be performed, anesthesiology providers and facilities must be on the CareSource provider panel. Selected patients requiring sedation may benefit from brief conscious sedation.

Inconclusive or Non-Supportive Evidence

Published evidence for *thoracic spine facet neurotomy* is limited due to lack of literature. [16, 20] For thoracic spinal pain this limited evidence shows an incomplete assessment of net benefits and potential harms of thoracic facet neurotomy.



For sacroiliac spine pain, evidence is limited and only two studies are available, with pain relief at 6 months after neurotomy ranging for 32% to 67%. [21]

Intra-articular facet joint injection for neck and back pain has limited evidence and efficacy has not been established. Due to poor evidence for efficacy intra-articular facet joint injections are not covered as a medically necessary health service.[11, 22]

Clinical Indications for Procedure

Facet neurotomy is indicated when **ALL** of the following criteria are met:

- One or two fluoroscopically-guided controlled local anesthetic blocks of medial branches of dorsal spinal nerves was previously performed on the same spinal region and vertebral location within 12 months prior to this request. This block confirmed that a vertebral facet joint medial nerve is a source of spinal, non-radiating pain by **ALL** of the following
 - Prior injection achieved at least 50% pain relief from baseline pain scores.
 - After diagnostic block, the patient had the ability to perform previously painful movement without deterioration of the relief (i.e., extension, overhead activity, lateral rotation, flexion, etc.)
- Limited number of prior facet neurotomies, as indicated by **1 or more** of the following:
 - No prior history of facet neurotomy
 - Prior history of not more than a series of 3 successful single or multilevel facet neurotomies, each providing at least **6 months or more** of pain relief in same region (e.g., cervical or lumbar region)
- Radiofrequency neurotomy will be performed using percutaneous introduction of an electrode under fluoroscopic guidance to thermocoagulate medial branches of the dorsal spinal nerves.
- The primary region of spine pain is located either the cervical spine or lumbar spine
- The patient has received conservative treatment after the onset of this specific condition, and within the past 24 months, including **2 or more** of the following, including contemporaneous notes in the medical record of the service provider for:
 - Chiropractor visits
 - Physical therapy sessions
 - Exercise program
 - Medications for pain
- The conservative therapy was tried for **3 months or more** after the onset of pain
- Imaging studies have ruled out other causes of spinal pain (examples include herniated disc, spinal stenosis; fracture or tumor), and were completed within the 24 months prior to the date of this request.
- No bleeding disorder
- The patient is currently not on blood thinner medication
- No current infection

For Medicare Plan members, reference the below link to search for Applicable National Coverage Descriptions (NCD) and Local Coverage Descriptions (LCD):

<http://www.cms.gov/medicare-coverage-database>

If there is no NCD or LCD present, reference the CareSource Policy for coverage.

CONDITIONS OF COVERAGE

HCPCS None

CPT 64633, 64634, 64635, 64636, 0213T, 0214T, 0215T, 0216T, 0217T, 0218T



AUTHORIZATION PERIOD

E. REVIEW/REVISION HISTORY

Date Issued: 01/27/2105
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F. REFERENCES

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"This guideline contains custom content that has been modified from the standard care guidelines and has not been reviewed or approved by MCG Health, LLC."

The medical Policy Statement detailed above has received due consideration as defined in the Medical Policy Statement Policy and is approved.