CareSource

MEDICAL POLICY STATEMENT
GEORGIA MEDICAID

Original Issue Date	Next Annual Review	Effective Date
02/22/2018	07/15/2019	07/15/2018
Policy Name		**Policy Number**
Facet Neurotomy		MM-0216
Policy Type		
MEDICAL	Administrative / Pharmacy	Reimbursement

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Contents of Policy

A. SUBJECT

Facet Neurotomy

B. BACKGROUND

Interventional procedures for management of acute and chronic pain are part of a comprehensive pain management care plan that incorporates conservative treatment in a multimodality approach. Multidisciplinary treatments include promoting patient self-management and aim to reduce the impact of pain on a patient's daily life, even if the pain cannot be relieved completely. Interventional procedures for the management of pain unresponsive to conservative treatment should be provided only by physicians qualified to deliver these health services.

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). 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. 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.

C. DEFINITIONS

- **Radiofrequency neurotomy** is performed using percutaneous introduction of an electrode under fluoroscopic guidance to thermocoagulate medial branches of the dorsal spinal nerves
- A **zygapophyseal (aka facet) joint "level"** refers to the zygapophyseal joint or the two medial branch (MB) nerves that innervate that zygapophyseal joint
- A **"session"** is defined as all injections/blocks/RF procedures performed on one day and includes medial branch blocks (MBB), intraarticular injections (IA), facet cyst ruptures, and radiofrequency (RF) ablations
- **Conservative therapy** is a multimodality plan of care. Start and end dates in the medical record substantiate duration of treatment. **Multimodality care plans include BOTH of the following:**
  - **Active conservative therapies** such as physical therapy, occupational therapy, a physician supervised home exercise program (HEP), or chiropractic care
  - **Home Exercise Program (HEP):** includes two components that are both required to meet CareSource policy for completion of conservative therapy:
    - Information provided for an exercise prescription and/or plan documented in the medical record AND follow up documented in the medical record with member with information provided regarding completion of HEP (after suitable six (6) week period), or inability to complete HEP due to a stated physical reason- i.e. increased pain, inability to physically perform exercises. (Patient inconvenience or noncompliance without explanation does not constitute "inability to complete")
  - **Inactive conservative therapies** such as rest, ice, heat, medical devices, acupuncture, TENS unit, prescription medications.
    - If a TENS unit is part of the care plan, the frequency of use, and duration of use with dates must be documented in the medical record. General statements in the medical record such as "Patient has a TENS unit" do not document use, and will not suffice to

meet this policy criterion.

- A **TENS unit is a Transcutaneous Electrical Nerve Stimulator** is a durable medical equipment device dispensed by prescription. It use, frequency, duration, and start dates must be documented in the medical record to be considered part of conservative therapy during the period of prior authorization request.

- A **"successful" DIAGNOSTIC facet medial branch nerve block injection** in this policy is defined as an injection that achieves greater than 50% reduction in pain within the duration of effectiveness for the anesthetic used.
- A **"successful" THERAPEUTIC facet medial branch nerve block injection** in this policy is defined as an injection that achieves greater than 50% reduction in pain for at least 6 months.

D. POLICY

I. Criteria

A prior authorization is required for each facet medial branch nerve block injection for pain management.

A. Facet medial branch neurotomy is indicated when **ALL of the following** criteria are met:
   1. Spine pain is predominantly axial and non-radiating and is located in either the cervical, thoracic, or lumbar spine.
   2. Prior history in the past 24 months includes **1 or more of the following**:
      2.1 One or Two fluoroscopically-guided controlled local anesthetic blocks of medial branch nerves achieved 50% or more relief at the same spinal region and vertebral location within 12 months prior to this request.
      2.2 Prior history of 1 successful single or multilevel facet neurotomy, each providing at least 6 months or more duration of pain relief in same region (e.g., cervical or lumbar region)
   3. ACTIVE conservative therapy as part of a multimodality comprehensive approach is addressed in the patient's care plan with documentation in the medical record that includes at least **ONE of the following:**
      3.1 The patient has received ACTIVE conservative therapy lasting for six (6) weeks or more within the past six (6) months with start and end dates in the medical record substantiating the duration of treatment including **ONE of the following:**
         a. Physical therapy
         b. Occupational therapy
         c. A physician supervised home exercise program (HEP) as defined in CareSource policy
         d. Chiropractic care
      3.2 Or, the medical record documents at least **ONE of the following** exceptions to the 6 weeks ACTIVE conservative therapy requirement in the past 6 months:
         a. At least moderate pain with significant functional loss at work or home
         b. Severe pain unresponsive to outpatient medical management
         c. Inability to tolerate non-surgical, non-injection care due to co-existing medical condition(s)
         d. Prior successful injections for same specific condition with relief of at least 3 months' duration (start and end dates are documented in the medical record).
   4. PASSIVE conservative therapy as part of a multimodality comprehensive approach is addressed in the patient's care plan. Documentation in the medical record reflecting passive conservative therapy lasting for six (6) weeks or more within the past six (6) months with start and end dates in the medical record substantiating the duration of treatment that includes at least **ONE of the following:**
      4.1 rest
      4.2 ice
      4.3 heat
      4.4 medical devices

4.5 acupuncture
4.6 TENS unit use as defined in CareSource policy
4.7 prescription pain medications

5. Relevant imaging studies of the painful spinal region were completed within the 36 months prior to the date of this request
6. Evidence for **cervical spine facet neurotomy** is Level II-1 (criteria as described by the Agency for Healthcare Research and Quality [AHRQ] and the US Preventative Services Task Force (USPSTF). 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.
7. Evidence for **lumbar spine facet neurotomy** is Level II-2 with favorable results at less than 6 months post-procedure.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.
8. If requested, a repeat neurotomy in the same spine region requires that a 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, involving no more than four (4) joints per session, e.g., two (2) bilateral levels or four (4) unilateral levels). 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 that is documented in the contemporaneous medical record.

B. CareSource will consider a Facet Medial Branch Neurotomy medically necessary for treatment of non-radiating pain that is unresponsive to a well-managed course of conservative therapy when the following criteria exist:
   1. 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
   2. Diagnostic studies including x-rays and MRIs where appropriate that have confirmed the diagnosis of facet arthropathy or degenerative disease of the spine.
   3. 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. 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) 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. Evidence is Level I or II-1 for diagnostic lumbar facet medial branch nerve block injections and good for therapeutic lumbar facet medial branch nerve block injections in 11 randomized trials

Prior to interventions, imaging studies should rule out other causes of spinal pain (examples include herniated disc, spinal stenosis, fracture or tumor). These imaging studies are completed within the 36 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 medically 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 credentialed provider

panel. Selected patients requiring sedation may benefit from brief conscious sedation but this is not covered if a second provider is required to deliver conscious sedation.

Inconclusive or Non-Supportive Evidence

Published evidence for *thoracic spine facet neurotomy* is limited due to lack of literature. 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%. This policy does not address sacral conditions or injections or neurotomies.

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.

E. CONDITIONS OF COVERAGE

HCPCS
CPT
AUTHORIZATION PERIOD

F. RELATED POLICIES/RULES

Pain Management GA MCD PY-0432

G. REVIEW/REVISION HISTORY

DATES		ACTION
Date Issued	02/22/2018	New Policy.
Date Revised		
Date Effective	07/15/2018	

H. REFERENCES

1. R. Chou, A. Qaseem, V. Snow, D. Casey, J. T. Cross, Jr., P. Shekelle, *et al.*, "Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society," *Ann Intern Med,* vol. 147, pp. 478-91, Oct 2 2007.
2. R. Chou, L. H. Huffman, S. American Pain, and P. American College of, "Nonpharmacologic therapies for acute and chronic low back pain: a review of the evidence for an American Pain Society/American College of Physicians clinical practice guideline," *Ann Intern Med,* vol. 147, pp. 492-504, Oct 2 2007.
3. R. Chou, L. H. Huffman, S. American Pain, and P. American College of, "Medications for acute and chronic low back pain: a review of the evidence for an American Pain Society/American College of Physicians clinical practice guideline," *Ann Intern Med,* vol. 147, pp. 505-14, Oct 2 2007.
4. R. Chou, J. D. Loeser, D. K. Owens, R. W. Rosenquist, S. J. Atlas, J. Baisden, *et al.*, "Interventional therapies, surgery, and interdisciplinary rehabilitation for low back pain: an evidence-based clinical practice guideline from the American Pain Society," *Spine,* vol. 34, pp. 1066-1077, 2009.
5. L. Manchikanti, S. Abdi, S. Atluri, R. M. Benyamin, M. V. Boswell, R. M. Buenaventura, *et al.*, "An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations," *Pain Physician,* vol. 16, pp. S49-283, Apr 2013.
6. L. Manchikanti, F. J. Falco, V. Singh, R. M. Benyamin, G. B. Racz, S. Helm, 2nd, *et al.*, "An update of comprehensive evidence-based guidelines for interventional techniques in chronic

spinal pain. Part I: introduction and general considerations," *Pain Physician,* vol. 16, pp. S1-48, Apr 2013.
7. L. Manchikanti, R. M. Benyamin, S. Helm, and J. A. Hirsch, "Evidence-based medicine, systematic reviews, and guidelines in interventional pain management: part 3: systematic reviews and meta-analyses of randomized trials," *Pain Physician,* vol. 12, pp. 35-72, Jan-Feb 2009.
8. L. Manchikanti, M. V. Boswell, S. Datta, B. Fellows, S. Abdi, V. Singh*, et al.*, "Comprehensive review of therapeutic interventions in managing chronic spinal pain," *Pain Physician,* vol. 12, pp. E123-98, Jul-Aug 2009.
9. L. Manchikanti, S. Datta, R. Derby, L. R. Wolfer, R. M. Benyamin, J. A. Hirsch*, et al.*, "A critical review of the American Pain Society clinical practice guidelines for interventional techniques: part 1. Diagnostic interventions," *Pain Physician,* vol. 13, pp. E141-74, May-Jun 2010.
10. S. West, V. King, T. S. Carey, K. N. Lohr, N. McKoy, S. F. Sutton*, et al.*, "Systems to rate the strength of scientific evidence," *Evid Rep Technol Assess (Summ),* pp. 1-11, Mar 2002.
11. R. P. Harris, M. Helfand, S. H. Woolf, K. N. Lohr, C. D. Mulrow, S. M. Teutsch*, et al.*, "Current methods of the US Preventive Services Task Force: a review of the process," *Am J Prev Med,* vol. 20, pp. 21-35, Apr 2001.
12. M. Smuck, R. A. Crisostomo, K. Trivedi, and D. Agrawal, "Success of initial and repeated medial branch neurotomy for zygapophysial joint pain: a systematic review," *PM R,* vol. 4, pp. 686-92, Sep 2012.
13. F. J. Falco, S. Datta, L. Manchikanti, N. Sehgal, S. Geffert, V. Singh*, et al.*, "An updated review of the diagnostic utility of cervical facet joint injections," *Pain Physician,* vol. 15, pp. E807-38, Nov-Dec 2012.
14. L. Manchikanti, V. Singh, F. J. Falco, K. A. Cash, and B. Fellows, "Comparative outcomes of a 2-year follow-up of cervical medial branch blocks in management of chronic neck pain: a randomized, double-blind controlled trial," *Pain Physician,* vol. 13, pp. 437-50, Sep-Oct 2010.
15. L. Manchikanti, V. Singh, F. J. Falco, K. A. Cash, V. Pampati, and B. Fellows, "The role of thoracic medial branch blocks in managing chronic mid and upper back pain: a randomized, double-blind, active-control trial with a 2-year followup," *Anesthesiol Res Pract,* vol. 2012, p. 585806, 2012.
16. F. J. Falco, L. Manchikanti, S. Datta, N. Sehgal, S. Geffert, O. Onyewu*, et al.*, "An update of the effectiveness of therapeutic lumbar facet joint interventions," *Pain Physician,* vol. 15, pp. E909-53, Nov-Dec 2012.
17. L. Manchikanti, V. Singh, F. J. Falco, K. A. Cash, and V. Pampati, "Evaluation of lumbar facet joint nerve blocks in managing chronic low back pain: a randomized, double-blind, controlled trial with a 2-year follow-up," *Int J Med Sci,* vol. 7, pp. 124-35, 2010.
18. K. N. Manchikanti, S. Atluri, V. Singh, S. Geffert, N. Sehgal, and F. J. Falco, "An update of evaluation of therapeutic thoracic facet joint interventions," *Pain Physician,* vol. 15, pp. E463-81, Jul-Aug 2012.
19. S. Datta, M. Lee, F. J. Falco, D. A. Bryce, and S. M. Hayek, "Systematic assessment of diagnostic accuracy and therapeutic utility of lumbar facet joint interventions," *Pain Physician,* vol. 12, pp. 437-60, Mar-Apr 2009.

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

Independent medical review – 02/2018