Facet Joint Interventions for Pain Management

Medicare Advantage Medical Policy No.: MNG-021

The Health Plan reserves the right to amend this policy and procedure at any time. Exceptions to this policy and procedure will be made on a case-by-case basis at the total discretion of the Health Plan.

Effective Date: May 28, 2024

Instructions for use

This policy serves to provide guidance in determining coverage based on medical necessity. It also gives a list of resources used to create these guidelines. Medical necessity determinations will be made in accordance with generally accepted standards of medical practice, taking into account credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of the physicians practicing in relevant clinical areas, and other relevant factors, as they relate to the member's clinical circumstances.

Medicare Advantage Members

Coverage criteria for Medicare Advantage members can be found in Medicare coverage guidelines in statutes, regulations, National Coverage Determinations (NCD)s and Local Coverage Determinations (LCD)s. To determine if a National or Local Coverage Determination addresses coverage for a specific service, refer to the Medicare Coverage Database at the following link: www.cms.gov/medicare-coverage-database/search.aspx. You may wish to review the Guide to the MCD Search here: www.cms.gov/medicare-coverage-database/help/mcd-bene-help.aspx.

When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, internal coverage criteria will be developed. This policy is to serve as the summary of evidence, a list of resources and an explanation of the rationale that supports the adoption of the coverage criteria and is to be used by all plans and lines of business unless Federal or State law, contract language, including member or provider contracts, take precedence over the policy.

Basic Requirements for Clinical Appropriateness:

1. Before diagnostic or therapeutic intervention, a clinician must confirm the diagnosis or establish the likelihood based on a history and physical exam and, when appropriate, a review of laboratory studies, previous diagnostic testing and response to any prior interventions, specifically relevant to the clinical situation.
2. An alternative treatment or other appropriate intervention should not offer any greater benefit based on standards of medical practice and/or current literature.
3. The potential benefit to the patient should outweigh the risk of the diagnostic or therapeutic intervention.
4. A reasonable likelihood of the intervention changing management and/or leading to an improved outcome for the patient must exist, based on the clinical evaluation, current literature and standards of medical practice.

If these requirements are not apparent in the request for authorization, including the clinical documentation provided, the determination of appropriateness will most likely require a peer-to-peer conversation to understand the individual and unique facts that would supersede the requirements set forth above. During the peer-to-peer conversation, factors such as patient acuity and setting of service may also be taken into account.

Simultaneous ordering of multiple diagnostic or therapeutic interventions and/or repeated diagnostic or therapeutic interventions in the same anatomic area may be denied, unless individual circumstances support the medical necessity of performing interventions simultaneously or repeatedly. This should be apparent in the clinical documentation or in peer-to-peer conversations.

Facet Joint Interventions for Pain Management

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Health Plan may consider facet joint interventions as a treatment for pain management to be eligible for coverage.**

When Services are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Health Plan considers the use of epoetin alfa (Epogen or Procrit)‡, epoetin alfa-epbx (Retacrit)‡, darbopoetin alfa (Aranesp)‡ or pegylated epoetin beta (Mircera)‡ for non-FDA approved indications to be investigational.* Off label use may be considered with appropriate clinical documentation.

Based on review of available data, the Health Plan considers injection of allograft (e.g., VIA Disc Matrix) into the intervertebral disc for the treatment of degenerative disc disease as not covered, as it is considered investigational.*

Covered Indications for Facet Joint Interventions

Facet Joint Interventions generally consist of 4 types of procedures: Intraarticular (IA) Facet Joint Injections, Medial Branch Blocks (MBB), Radiofrequency Ablations (RFA) and Facet cyst rupture/aspiration:

Facet Joint Interventions are considered medically reasonable and necessary for the diagnosis and treatment of chronic pain in patients who meet ALL the following criteria:

1. Moderate to severe chronic neck or low back pain, predominantly axial, that causes functional deficit measured on pain or disability scale*
2. Pain present for minimum of 3 months with documented failure to respond to noninvasive conservative management (as tolerated)

3. Absence of untreated radiculopathy or neurogenic claudication (except for radiculopathy caused by facet joint synovial cyst)
4. There is no non-facet pathology per clinical assessment or radiology studies that could explain the source of the patient's pain, including but not limited to fracture, tumor, infection or significant deformity.

*Pain assessment must be performed and documented at baseline, after each diagnostic procedure and at each follow-up using the same pain scale for each assessment. A disability scale must also be obtained at baseline to be used for functional assessment (if patient qualifies for treatment).

A. Diagnostic Facet Joint Procedures (IA or MBB):

The primary indication of a diagnostic facet joint procedure is to diagnose whether the patient has facet syndrome. Intraarticular (IA) facet block(s) are considered reasonable and necessary as a diagnostic test only if medial branch blocks (MMB) cannot be performed due to specific documented anatomic restrictions or there is an indication to proceed with therapeutic intraarticular injections. These restrictions must be clearly documented in the medical record and made available upon request.

Diagnostic procedures should be performed with the intent that if successful, radiofrequency ablation (RFA) procedure would be considered the primary treatment goal at the diagnosed level(s).

A second diagnostic facet procedure is considered medically necessary to confirm validity of the initial diagnostic facet procedure when administered at the same level. The second diagnostic procedure may only be performed a minimum of 2 weeks after the initial diagnostic procedure. Clinical circumstances that necessitate an exception to the 2-week duration may be considered on an individual basis and must be clearly documented in the medical record.

For the first diagnostic facet joint procedure:

1. For the first diagnostic facet joint procedure to be considered medically reasonable and necessary, the patient must meet the criteria outlined under indications for facet joint interventions.
2. A second confirmatory diagnostic facet joint procedure is considered medically reasonable and necessary in patients who meet ALL the following criteria:
    i. The patient meets the criteria for the first diagnostic procedure; AND
    ii. After the first diagnostic facet joint procedure, there must be a consistent positive response of at least 80% relief of primary (index) pain (with the duration of relief being consistent with the agent used).

Frequency limitation: For each covered spinal region, no more than four (4) diagnostic joint sessions will be reimbursed per rolling 12 months, in recognition that the pain generator cannot always be identified with the initial and confirmatory diagnostic procedure.

B. Therapeutic Facet Joint Procedures (IA or MBB):

Therapeutic facet joint procedures are considered medically reasonable and necessary for patients who meet ALL the following criteria:

1. The patient has had two (2) medically reasonable and necessary diagnostic facet joint procedures with each one providing a consistent minimum of 80% relief of primary (index) pain (with the duration of relief being consistent with the agent used); Or 1 injection with 100% pain relief, AND
2. Subsequent therapeutic facet joint procedures at the same anatomic site results in at least consistent 50% pain relief for at least three (3) months from the prior therapeutic procedure or at least 50% consistent improvement in the ability to perform previously painful movements and ADLs as compared to baseline measurement using the same scale; AND
3. Documentation of why the patient is not a candidate for radiofrequency ablation (such as established spinal pseudarthrosis, implanted electrical device)

Frequency Limitations: For each covered spinal region no more than four (4) therapeutic facet joint (IA) sessions will be reimbursed per rolling 12 months.

C. Facet Joint Denervation:

The thermal radiofrequency destruction of cervical, thoracic, or lumbar paravertebral facet joint (medial branch) nerves are considered medically reasonable and necessary for patients who meet ALL the following criteria:

1. Initial thermal RFA:
    i. After the patient has had One (1) or two (2) medically reasonable and necessary diagnostic MBBs as described above, with each one providing a consistent minimum of 80% sustained relief of primary (index) pain (with the duration of relief being consistent with the agent used) AND
    ii. Repeat thermal facet joint RFA at the same anatomic site is considered medically reasonable and necessary provided the patient had a minimum of consistent 50% improvement in pain for at least six (6) months or at least 50% consistent improvement in the ability to perform previously painful movements and ADLs as compared to baseline measurement using the same scale;

Frequency Limitation: For each covered spinal region no more than two (2) radiofrequency sessions will be reimbursed per rolling 12 months.

D. Facet Cyst Aspiration/Rupture

Intra-articular facet joint injection performed with synovial cyst aspiration is considered medically necessary when both of the following criteria are met:

1. Advanced diagnostic imaging study (e.g. MRI/CT/myelogram) confirm compression or displacement of the corresponding nerve root by a facet joint synovial cyst; AND
2. Clinical and physical symptoms related to synovial facet cyst are documented

Frequency Limitation: Cyst aspiration/rupture may be repeated once and only if there is 50% or more consistent improvement in pain for at least three (3) months.

Limitations

1. Facet joint interventions done without CT or fluoroscopic guidance are considered not reasonable and necessary. This includes facet joint interventions done without any guidance, performed under ultrasound guidance, or with magnetic resonance imaging (MRI).
2. General anesthesia is considered not reasonable and necessary for facet joint interventions. Neither conscious sedation nor monitored anesthesia care (MAC) is routinely necessary for intraarticular facet joint injections or medial branch blocks and are not routinely reimbursable. Individual consideration may be given on redetermination (appeal) for payment in rare, unique circumstances if the medical necessity of sedation is unequivocal and clearly documented in the medical record. Frequent reporting of these services together may trigger focused medical review.
3. It is not expected that patients will routinely present with pain in both cervical/thoracic and lumbar spinal regions. Therefore, the routine performance of facet joint interventions (both diagnostic and therapeutic) are limited to 1 spinal region per session.
4. It is not routinely necessary for multiple blocks (e.g., epidural injections, sympathetic blocks, trigger point injections, etc.) to be provided to a patient on the same day as facet joint procedures. Multiple blocks on the same day could lead to improper or lack of diagnosis. If performed, the medical necessity of each injection (at the same or a different level[s]) must be clearly documented in the medical record. For example, the performance of both paravertebral facet joint procedures(s) and a transforaminal epidural injection (TFESI) at the same or close spinal level at the same encounter would not be expected unless a synovial cyst is compressing the nerve root. In this situation, TFESI may provide relief for the radicular pain, while the facet cyst rupture allows nerve root decompression. Frequent reporting of multiple blocks on the same day may trigger a focused medical review.
5. Facet joint intraarticular injections and medial branch blocks involve the use of anesthetic, corticosteroids, anti-inflammatories and/or contrast agents, and does not include injections of biologicals or other substances not FDA designated for this use.
6. One to 2 levels, either unilateral or bilateral, are allowed per session per spine region. The need for a 3 or 4-level procedure bilaterally may be considered under unique circumstances and with sufficient documentation of medical necessity on appeal. A session is a time period, which includes all procedures (i.e., medical branch blocks (MBB), intraarticular injections (IA), facet cyst ruptures, and RFA ablations) that are performed during the same day.
7. If there is an extended time, 1 year or more, since the last RFA and/or there is a question as to the source of the recurrent pain then diagnostic procedures must be repeated.
8. Therapeutic intraarticular facet injections are not covered unless there is justification in the medical documentation on why RFA cannot be performed.

The following are considered not reasonable and necessary and therefore will be denied:

1. Intraarticular and extraarticular facet joint prolotherapy
2. Non-thermal modalities for facet joint denervation including chemical, low-grade thermal energy (less than 80 degrees Celsius), laser neurolysis, and cryoablation.
3. Intra-facet implants

4. Facet joint procedure performed after anterior lumbar interbody fusion or ALIF.
5. Definitive clinical and/or imaging findings pointing to a specific diagnosis other than facet joint syndrome.
6. Diagnostic injections or MMB at the same level as the previously successful RFA procedure.

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Health Plan may consider facet joint interventions when the coverage criteria are not met and for all other indications to be investigational*.

References

1. Cohen SP, Bhaskar A, Bhatia A, et al. Consensus practice guidelines on interventions for lumbar facet joint pain from a Multispecialty, International Working group. Regional Anesthesia Pain Medicine. 2020;45(6):424-467.
2. Society NAS. Evidence-Based Clinical Guidelines for Multidisciplinary Spine Care: Diagnosis & Treatment of Low Back Pain. 2020; https://www.spine.org/Portals/0/assets/downloads/ResearchClinicalCare/Guidelines/LowBackPain.pdf. Accessed 2/14/2023, 2020.
3. Manchikanti L, Kaye A, Soin A, et al. Comprehensive Evidence-Based Guidelines for Facet Joint Interventions in the Management of Chronic Spinal Pain: American Society of Interventional Pain Physicians (ASIPP) Guidelines Facet Joint Interventions 2020 Guidelines. J Pain Physician. 2020;23(3S):S1-S127.
4. North American Spine Society (NASS. Facet Joint Interventions | NASS Coverage Policy Recommendations. NASS Coverage Committee. 2017. www.spine.org.
5. Greater Manchester Combined Authority Greater Manchester EUR Policy Statement on: Facet Joint Injections for Neck and Back Pain. GM Ref: GM070 2018;Version 2.2: http://northwestcsu.nhs.uk/BrickwallResource/GetResource/d5f134e0-aab1-4be3-9475-3f973f126423. Accessed 02/14/2023.
6. Lee DW, Pritzlaff S, Jung MJ, et al. Latest Evidence-Based Application for Radiofrequency Neurotomy (LEARN): Best Practice Guidelines from the American Society of Pain and Neuroscience (ASPN). J Pain Res. 2021;14:2807-31.
7. Manchikanti L, Kaye AD, Soin A, et al. Comprehensive Evidence-Based Guidelines for Facet Joint Interventions in the Management of Chronic Spinal Pain: American Society of Interventional Pain Physicians (ASIPP) Guidelines Facet Joint Interventions 2020 Guidelines. Pain physician. 2020;23(3S):S1-S127.
8. Manchikanti L, Knezevic NN, Navani A, et al. Epidural Interventions in the Management of Chronic Spinal Pain: American Society of Interventional Pain Physicians (ASIPP) Comprehensive Evidence-Based Guidelines. Pain physician. 2021;24(S1):S27-S208.

Policy History

Original Effective Date: 05/28/2024

05/28/2024: Utilization Management Committee Review and approval

Coding

The five-character codes included in this medical policy are obtained from Current Procedural Terminology (CPT®)‡, copyright 2024 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physician.

The responsibility for the content of the Health Plan Medical Policy Coverage Guidelines is with the Health Plan and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in the Health Plan Medical Policy Coverage Guidelines. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

CPT is a registered trademark of the American Medical Association.

Codes used to identify services associated with this policy may include (but may not be limited to) the following:

Code Type	Code
CPT	0213T, 0214T, 0215T 0216T, 0217T, 0218T, 64490, 64491, 64492, 64493, 64494, 64495
HCPCS	No codes
ICD-10 Diagnosis	All related diagnoses

*Investigational – A medical treatment, procedure, drug, device or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device or biological product is Investigational will be based on a consideration of the following:

A. Whether the medical treatment, procedure, drug, device or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device or biological product is sought to be furnished; or

B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness or effectiveness as compared with the standard means of treatment or

diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:

1. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
2. Reference to federal regulations.

**Medically Necessary (or "Medical Necessity") - Healthcare services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;

B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and

C. Not primarily for the personal comfort or convenience of the patient, physician or other healthcare provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: If the Patient's health insurance contract contains language that differs from the Health Plan Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Health Plan recommends, advocates, requires, encourages, or discourages any particular treatment, procedure or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.