CareSource

MEDICAL POLICY STATEMENT

# INDIANA MEDICAID

| Policy Name | Policy Number | Date Effective |
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| Facet Medial Branch Nerve Blocks | MM-0186 | 08/01/2019 |

| Policy Type | | | |
|---|---|---|---|
| MEDICAL | Administrative | Pharmacy | Reimbursement |

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## A. Subject

**Facet Medial Branch Nerve Blocks**

## 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.

Facet medial branch nerve blocks are one of the methods to diagnose and treat posterior biomechanical pain of the back which predominantly does not have a strong radicular component. Evidence supports the use of a Facet Medial Branch Nerve Block as a diagnostic tool to identify the cause of pain and as an option for providing short term pain relief with the use of certain medications. A presumptive diagnosis of facet joint pain is made clinically. Evaluations include response to facet loading on physical examination, and plain radiography or axial imaging indicating facet hypertrophy localized to the painful region. This may be confirmed by relief of pain through injection of local anesthetic to the medial branches of the posterior rami of the dorsal spinal nerves supplying the proposed facet joint(s). Pain is predominantly axial and, with the possible exception of facet joint cysts, not associated with radiculopathy or neurogenic claudication. There must be no non-facet pathology that could explain the source of the patient's pain, such as fracture, tumor, infection, or significant deformity. Facet medial branch nerve blocks may be performed at the targeted joint itself, one joint above and one joint below on the same side, or bilaterally per treatment session. Facet medial branch nerve block injections should be performed with imaging guidance.

In the diagnostic phase, a patient receives injection of short-acting local anesthetic agent to identify the pain generator. For those whose pain recurs and persists to a moderate-severe degree after positive diagnostic facet injection, interventional options may include a facet neurotomy which ablates the nerve, or facet medial branch nerve block injection(s), once the diagnostic phase is completed.

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 additional injections, three 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 lumbar facet medial branch nerve block injections in 11 randomized trials.

**Professional Society Recommendations**: The following professional society's recommendations are derived from the latest guidelines and scientific based literature available

## American College of Physicians (ACP) & American Pain Society (APS) (October 2007)

Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society.

- Clinicians should conduct a focused history and physical examination to help place patients with low back pain into 1 of 3 broad categories: nonspecific low back pain, back pain potentially associated with radiculopathy or spinal stenosis, or back pain potentially associated with another specific spinal cause. The history should include assessment of psychosocial risk factors, which predict risk for chronic disabling back pain
- Clinicians should not routinely obtain imaging or other diagnostic tests in patients with nonspecific low back pain
- Clinicians should perform diagnostic imaging and testing for patients with low back pain when severe or progressive neurologic deficits are present or when serious underlying conditions are suspected on the basis of history and physical examination
- Clinicians should evaluate patients with persistent low back pain and signs or symptoms of radiculopathy or spinal stenosis with magnetic resonance imaging (preferred) or computed tomography only if they are potential candidates for surgery or epidural steroid injection
- Clinicians should provide patients with evidence-based information on low back pain with regard to their expected course, advise patients to remain active, and provide information about effective self-care options
- For patients with low back pain, clinicians should consider the use of medications with proven benefits in conjunction with back care information and self-care. Clinicians should assess severity of baseline pain and functional deficits, potential benefits, risks, and relative lack of long-term efficacy and safety data before initiating therapy. For most patients, first-line medication options are acetaminophen or nonsteroidal anti-inflammatory drugs
- For patients who do not improve with self-care options, clinicians should consider the addition of nonpharmacological therapy with proven benefits—for acute low back pain, spinal manipulation; for chronic or subacute low back pain, intensive interdisciplinary rehabilitation, exercise therapy, acupuncture, massage therapy, spinal manipulation, yoga, cognitive-behavioral therapy, or progressive relaxation

## American College of Physicians (ACP) (April 2017)

The ACP's recommendations for Noninvasive Treatments for Acute, Subacute and Chronic Low Back Pain: A Clinical Practice Guideline are as follows:

- Clinicians and patients should select nonpharmacological treatment with superficial heat (moderate-quality evidence), massage, acupuncture, or spinal manipulation (low-quality evidence). If pharmacologic treatment is desire, clinicians and patients should select nonsteroidal anti-inflammatory drugs or skeletal muscle relaxants (moderate-quality evidence)
- Clinicians and patients should initially select nonpharmacological treatment with exercise, multidisciplinary rehabilitation, acupuncture, mindfulness-based stress reduction, tai chi, yoga, motor control exercise, progressive relation, electromyography biofeedback, low – level laser therapy, operant therapy, cognitive behavioral therapy or spinal manipulation

- In patients with chronic low back pain who have had an inadequate response to nonpharmacological therapy, clinicians and patients should consider pharmacologic treatment with nonsteroidal anti-inflammatory drugs as first line therapy, or tramadol or duloxetine as second-line therapy. Clinicians should only consider opioids as an option in patients who have failed the aforementioned treatments and only if the potential benefits outweigh the risks for individual patients and after a discussion of known risks and realistic benefits with patients.

## C. Definitions

- A **zygapophyseal (aka facet) joint "level"** refers to the zygapophyseal joint or the two medial branch (MB) nerves that innervate that zygapophyseal joint
- **Diagnostic medial branch nerve block** refers to the diagnosis" of facet-mediated pain requiring the establishment of pain relief following medial branch blocks (MBB) or intra-articular injections (IA). Neither physical exam nor imaging has adequate diagnostic power to confidently distinguish the facet joint as the pain source
- 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, chiropractic care or a physician supervised home exercise program (HEP)
        - **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")
    - **Passive 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 3 months.

## D. Policy

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

A. Facet Medial Branch Nerve Block Injections are indicated when **ALL of the following** criteria are met:

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.
2. Relevant imaging studies of the painful spinal region were completed within the 36 months prior to the date of this request and there is no non-facet pathology that could explain the source of the patient's pain, such as fracture, tumor, infection, or significant deformity
3. Spine pain *is predominantly axial and non-radiating* and located in the cervical, thoracic, or lumbar spine. If pain is pseudo-radicular, the contemporaneous medical record must so state this finding:

1.1 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:**

a. 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:**
   (1) Physical therapy
   (2) Occupational therapy
   (3) A physician supervised home exercise program (HEP) as defined in CareSource policy
   (4) Chiropractic Care

b. 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:
   (1) At least moderate pain with significant functional loss at work or home
   (2) Severe pain unresponsive to outpatient medical management
   (3) Inability to tolerate non-surgical, non-injection care due to co-existing medical condition(s)
   (4) 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).

1.2 PASSIVE conservative therapy as part of a multimodality comprehensive approach is addressed in the patient's care plan with documentation in the medical record 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. rest
b. ice
c. heat
d. medical devices
e. acupuncture
f. TENS unit use as defined in CareSource policy
g. Pain medications (RX or OTC) such as: non-steroidal anti-inflammatory drugs (NSAIDS), acetaminophen.Opioid narcotics are not required for consideration.

B. Dual MBBs (a series of two MBBs) are necessary to diagnose facet pain due to the unacceptably high false positive rate of single MBB injections.
   1. A second confirmatory MBB is allowed if documentation indicates the first MBB produced significant relief of primary (index) pain ≥ 50%.

C. A maximum of six (6) facet injection sessions inclusive of medial branch blocks, intraarticular injections, and facet cyst rupture and facet medial branch neurtomies may be performed per rolling 12 months in the cervical/thoracic spine and six (6) in the lumbar spine.

D. Neither conscious sedation nor Monitored Anesthesia Care (MAC) is routinely necessary for intra-articular facet joint injections or medial branch blocks and are not routinely reimbursable. Individual consideration may be given for payment in rare unique circumstances if the medical necessity of sedation is unequivocal and clearly documented. Patients with indwelling implanted spinal cord stimulators or pain pumps should have a device interrogation report submitted with medical records for a prior authorization request for proposed interventional pain injections. If a device is not functioning properly, an escalation in pain may warrant evaluation and management of the implanted device.

III. **Inconclusive or Non-Supportive Evidence**

Facet medial branch nerve block injections are unproven for the treatment of chronic spinal pain and routine, periodic injections will not be authorized for management of chronic pain.

Intra-articular facet joint injection for neck and back pain has limited evidence and the efficacy not established. Intra-articular facet joint injection is a third option for managing axial back pain, however due to poor evidence for efficacy facet joint injections are therefore not covered. Intra-articular facet joint injections also do not qualify as diagnostic information for a future proposed neurotomy.

## E. Conditions of Coverage

## F. Related Polices/Rules

Pain Management PY-0127

## G. Review/Revision History

| | DATE | ACTION |
|---|---|---|
| **Date Issued** | 11/01/2017 | |
| **Date Revised** | 03/20/2019 | Annual Update: Addition of criteria: H & P, relevant imaging studies, 50% reduction in pain. Changed benefit limit to six injection sessions. |
| **Date Effective** | 08/01/2019 | |

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

*Independent medical review – 2/2018*

IN-P-0648 OMPP Approval: 05/10/2019