

MEDICAL POLICY STATEMENT

Marketplace

Policy Name & Number	Date Effective
Facet Joint Interventions-MP-MM-1326	08/01/2024
Policy Type	
MEDICAL	

Medical Policy Statement prepared by CareSource and its affiliates 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 CareSource and its affiliates 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



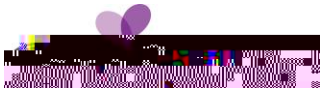
therapy, a physician supervised home exercise program (HEP), and/or chiropractic care.

HEP – A 6-week program requiring an exercise prescription and/or plan and a follow-up documented in the medical record after completion, or documentation of the inability to complete a HEP due to a stated physical reason (ie, increased pain, inability to physically perform exercises). Patient inconvenience or noncompliance without explanation does not constitute inability to complete.

- **Inactive Conservative Therapies** – Passive activities by the patient that aid in treating symptoms with pain including rest, ice, heat, medical devices, acupuncture, TENS use, and/or pharmacotherapy (prescription or over the counter [eg, NSAIDS, acetaminophen]).

Transcutaneous Electrical Nerve Stimulator (TENS) – A device that utilizes electrical current directed through electrodes placed on the surface of the skin to decrease the patient's perception of pain by inhibiting the transmission of afferent pain nerve impulses and/or stimulating the release of endorphins. Use, frequency, duration, and start dates must be documented in the medical record.

- **Medial Branch Nerve Block Injection** A diagnostic procedure in which a short-acting anesthetic (eg, lidocaine) is injected near small medial nerves connected to a specific facet joint. It may be performed to treat



4. Radiofrequency ablation is being considered as a therapeutic intervention.
 5. Injections should be at least 2 weeks apart.
 6. Imaging studies and physical exam ruled out other causes of spinal pain (eg, fracture, tumor, infection, herniated disk, spinal stenosis, significant deformity).
 7. Patient history with at least 3 months of moderate to severe pain with functional impairment that has not adequately responded to active and inactive conservative therapy.
 8. Failure of conservative therapy as evidenced by **ALL** of the following:
 - a. Documentation in the medical record of at least 6 weeks of active conservative therapy (as defined above) within the past 6 months OR inability to complete active conservative therapy due to contraindication, increased pain, or intolerance.
 - b. Documentation in the medical record of at least 6 weeks of inactive conservative therapy (as defined above) within the past six months.
 9. No coagulopathy.
 10. No current infection at the injection site.
- B. Diagnostic medial branch nerve blocks are **NOT** considered medically necessary when RFA is not being considered as a treatment option.
- II. Radiofrequency Ablation (RFA) for Facet Joint Pain
- A. Initial RFA for facet joint pain is considered medically necessary when in 600.34 Tme

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

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