		Number	Date Effective
Facet Joint Interventions		MM-0972	12/01/2021-10/31/2022
Policy Type			
MEDICAL	Administrative	Pharmacy	Reimbursement

Medical Policy Statement prepared by CareSource and its affiliates are derived from literature

Table of Contents

Facet Joint Interventions

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 (with the possible exception of facet joint cysts) and 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 an injection of a short-acting local anesthetic agent to identify the pain generator. For those whose pain recurs and persists to a moderate-severe degree after a positive diagnostic facet injection, interventional options may include a facet medial branch nerve block injection(s) or radiofrequency facet ablatiTc 0 Twf1 (di71 0 Td (.9 3.4 (t)-15.7 ( )]TJ 0.015 Tc -0.079 (c)1e)-71.7 4)-23.4 (in5 ())7.2R3 (r)62-9.2 (t)A)3

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.

Evidence for cervical spine radiofrequency facet ablation 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 radiofrequency ablation. If indicated, repeat cervical radiofrequency facet ablation is successful 67% to 95% of the time. Evidence for lumbar spine radiofrequency facet ablation 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 radiofrequency facet ablation. If indicated, repeat lumbar radiofrequency facet ablation is successful 33% to 85% of the time, with subsequent relief enduring for an average of 12 months.

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) (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 desired, 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; and;
- 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

- 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

II. Medial Branch Nerve Block Injections
   A. Up to two medial branch nerve block injections in the cervical/thoracic or lumbar regions are considered medically necessary.
      1. Only three (3) spinal levels (unilateral or bilateral) may be treated at the same time (maximum amount of six injections per rolling 12 months);
      2. A response of at least 50% pain relief must be achieved before the second injection is performed; and
      3. Injections should be at least two (2) weeks apart.
   B. All of the following criteria must be met:
      1. Patient must have a history of at least three (3) months of moderate to severe pain with functional impairment, and pain has not adequately responded to active or inactive conservative therapy.
      2. Spine pain is predominantly located within the axial skeleton, non-radiating (not moving to another area) and is focused in the cervical, thoracic or lumbar spine area.
         a. If pain is pseudo-radicular (pseudo-radicular pain does not radiate below the knee and is thought to be associated with local proximal disorders that do not affect any nerves or nerve roots), the medical record must state this finding.
      3. A thorough history and physical exam documenting the cause of the pain (if known), duration of symptoms, severity, exacerbating factors, abnormal physical and diagnostic findings and prior conservative treatment measures is required.
      4. Relevant imaging studies of the painful spinal region were completed within thirty-six (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.
      5. 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 (1) of the following:
         a. The patient has received ACTIVE conservative therapy lasting for six (6) weeks or more within the past six (6) months including ONE (1) of the following:
            01. Physical therapy;
            02. Occupational therapy;
            03. A physician supervised home exercise program (HEP) as defined in this policy; or
            04. Chiropractic care.
         b. OR, the medical record documents at least ONE (1) of the following exceptions to the six (6) weeks ACTIVE conservative therapy requirement in the past six (6) months:
            01. Moderate pain with significant functional loss at work or home
            02. Severe pain unresponsive to outpatient medical management
            03. Inability to tolerate non-surgical, non-injection care due to co-existing medical condition(s)
            04. Prior successful injections for same specific condition with relief of at least three (3) months' duration.

6. Inactive 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 including ONE (1) of the following:
   a. Rest;
   b. Ice;
   c. Heat;
   d. Medical devices;
   e. Acupuncture;
   f. TENS unit use as defined in this policy; or
   g. Pain medications (RX or OTC) such as: non-steroidal anti-inflammatory drugs (NSAIDS), acetaminophen. Opioid narcotics are not required for consideration.

III. Radiofrequency Facet Ablations (RFA)
   A. A maximum of four (4) radiofrequency facet ablations per rolling twelve (12) months (two left and two right per spinal region: cervical, thoracic or lumbar).
   B. Radiofrequency Facet Ablations are considered medically necessary when ALL of the following have been met in the last thirty-six (36) months:
      1. The clinical criteria above (II, B 1-6) have been met and ONE (1) of the following:
         a. Two (2) successful medial branch nerve block injections have been performed at the same spinal region achieving 50% or more pain relief; OR
         b. One (1) successful single or multilevel facet radiofrequency ablation session, in the same spinal region (cervical, thoracic or lumbar) and side providing at least 50% pain relief for a minimum of six (6) months.
   C. Repeat Radiofrequency Facet Ablation
      1. Repeat Radiofrequency Facet Ablation in the same spinal region and side is considered medically necessary when ALL of the following have been met:
         a. Documented pain relief of at least 50% or greater for a minimum of six (6) months after the initial RFA
         b. A minimum of six (6) months following the initial RFA.
      2. Repeat diagnostic medial branch nerve block injections are not considered medically necessary if the member has had a successful RFA in the last thirty-six (36) months.

IV. Sedation
   A. 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.
      1. Individual consideration may be given for payment in rare unique circumstances if the medical necessity of sedation is unequivocal and clearly documented.

2. R. Chou, R. Deyo, et al.(2017, April 4). "Nonpharmacologic Therpies for Low Back Pain: A Systematic Reivew for an American College of Physicians Clinical Practice Guideline," Retreived on July 1, 2021 from www.acpjournals.org
3. R. Chou, J. D. Loeser, D. K. Owens, R. W. Rosenquist, S. J. Atlas, J. Baisden*, et al. (2009, May 1)*,("Interventional therapies, surgery, and interdisciplinary rehabilitation for low back pain: an evidence-based clinical practice guideline from the American Pain Society," Retreived on July 1, 2021 from www.spinjournal.com
4. L. Manchikanti, S. Abdi, S. Atluri, R. M. Benyamin, M. V. Boswell, R. M. Buenaventura*, et al.*,(2013, April) "An update of comprehensive evidence-based